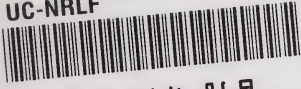
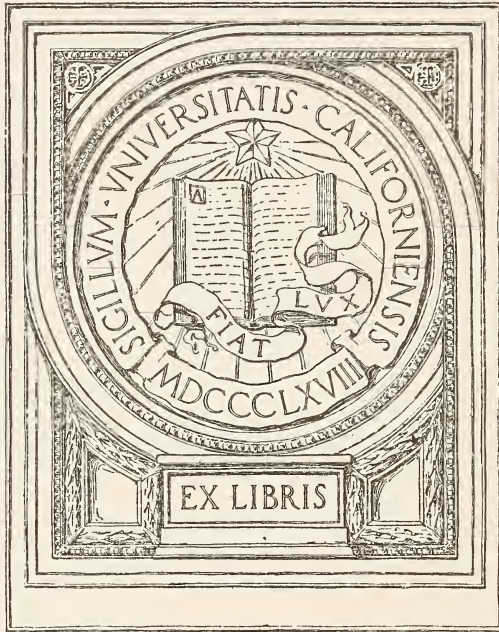


UC-NRLF

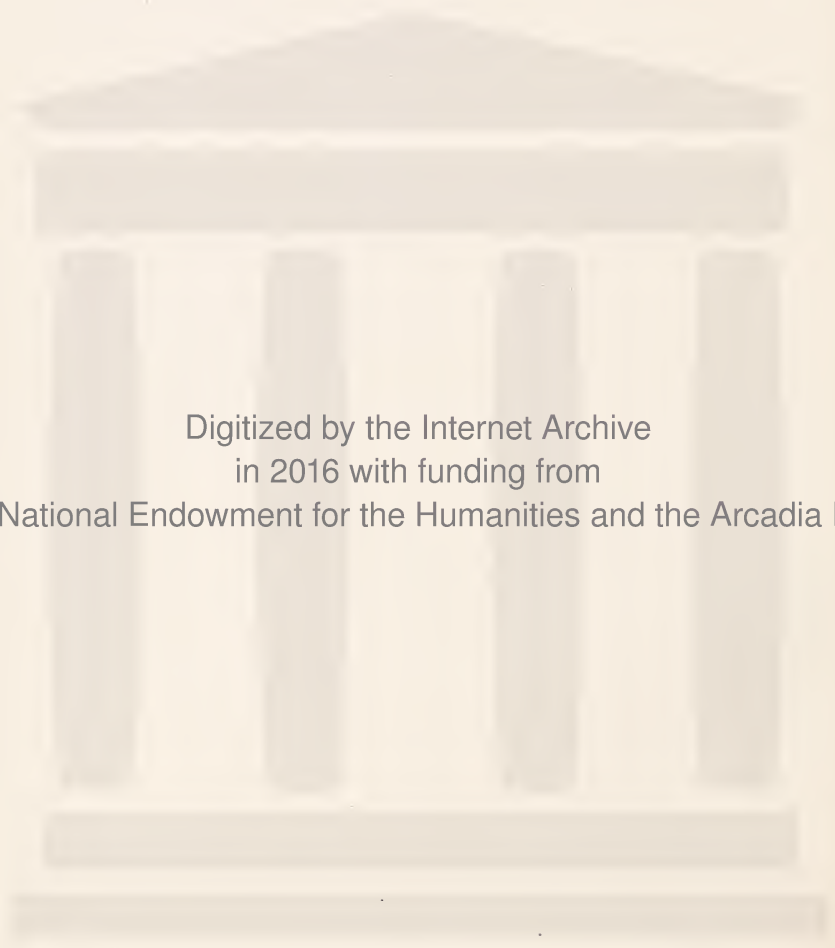


B 4 144 869

MEDICAL SCHOOL
LIBRARY



EX LIBRIS



Digitized by the Internet Archive
in 2016 with funding from
The National Endowment for the Humanities and the Arcadia Fund

THE JOURNAL

OF THE

MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY UNDER THE DIRECTION
OF THE BOARD OF TRUSTEES



Volume XXI.

January, 1924--December, 1924

Publication Committee:

DRS. CHARLES D. BENNETT, J. BENNETT MORRISON, EDWARD J. ILL
and DAVID C. ENGLISH.

14 South Day Street, Orange, N. J.

Editor:

DAVID C. ENGLISH, M.D.

INDEX.

All Original Articles are listed under the heading "Original Articles", with the authors' names. All Medical Societies' Reports will be found under "Societies". All Hospitals, Sanatoria and Homes will be found under "Hospitals".

A

ABSTRACTS—

Fracture Pains (Iowa State J. Med.).....	294
Malarial Treatment of General Paralysis (Kentucky Med. Jour.)	324
New Serum Treatment of Pneumonia (Rep. New England Health Institute)	295
Passing of the General Practitioner (Texas Med. Jour.)	303
Prognosis of Angina Pectoris (Medicine).....	324
Radiation for Inoperable Carcinoma of Breast (Radiology)	295
Radium Therapy of Cancer (Brit. Med. Jour.).....	294
Sudden Deaths Associated with Injections of Foreign Substances (Iowa State Med. Jour.).....	302
The Failing Heart (Boston M. & S. Jour.).....	301
Treatment of Carbuncle (Illinois Med. Jour.).....	294
Treatment of Epilepsy (Brit. Med. Jour., Jan. 6, 1923)	324
Annual Meeting A. M. A.....	296
Annual Meeting State Society:	
Announcement and Program	165
Official Transactions	297
Meeting of the Fellows	301

AUTHORS OF ORIGINAL ARTICLES:

Allen, Frederick M.: Timing of Insulin Doses....	223
Allen, Robert Emmet: Complications of Diabetes in Patients under Insulin Treatment	115
Anderson, John F.: Effect of Freezing on Diphtheria Toxin-Antitoxin Mixtures as Regards Toxicity	228
Anderson, John F.: Further Report on the Kahn and Wassermann Tests of Blood Serum and Spinal Fluid	132
Anderson, John F.: Preliminary Study of Antibody Relationship of Streptococcus and Bacillus Coli Groups	56
Andrews, Clarence L.: Interesting Case of Pernicious Anemia	224
Bass, Murray H.: Tuberculosis in Childhood....	124
Bassin, John N.: Prevention, Rehabilitation and Medicolegal Aspects of Sprained Back.....	216
Beardsley, Edward J. G.: Why the Public Consult the Pseudo Medical Cults	275
Bell, George Huston: Reform Diet in Ophthalmic Practice	6
Berne, Louis P.: Rhinoplasty from an Artist's Standpoint	121
Bishop, Louis Faugeres: Digitalis as a Stimulant	183
Blackburne, George: Surgical Treatment of the Sequels of Pneumonia	155
Bloodgood, Joseph Colt: Oration in Surgery: The Control of Cancer—A Problem in Education	307
Carman, Fletcher F.: Gastric and Duodenal Ulcer	1
Chambers, Talbot R.: Sinus Thrombosis	151
Chase, William Earle: Injuries of the Eye.....	189
Chayes, Sydney: Undernourished or Subnormal Child	43
Cobham, James L.: Transuterine Inflation or the Rubin Test	215
Curry, Marcus A.: Address to Alumni Association of Albany Medical College	221
Curtis, Donald A.: Clinical Report.....	94
Cutts, William B.: As Others See Us.....	157
D'Acerno, Pellegrino A.: Symptomatic versus Radical Treatment of Infections and Toxic Neuralgia, Neuritis and Allied Conditions.....	185
Danzis, Max: Local Anesthesia: Its Merits and Limitations	348
Darnall, Wm. Edgar: The Neurasthenic Abdomen	53
Davidson, Louis L.: Prostatic Hypertrophy.....	281
Dickinson, Gordon K.: The Musings of a Stomach	13
Eagleton, Wells P.: Presidential Address.....	337
Ellinger, Emily B.: Preliminary Study of Antibody Relationship of Streptococcus and Bacillus Coli Groups	56
Ewens, Arthur E.: A Method of Preventing Removal of Tonsils and Adenoids and Its Usefulness in Treating Nose and Throat Defects.....	25

Faulkner, E. Ross: Treatment of Sinusitis	75
Fine, M. J.: Treatment of Pulmonary Tuberculosis by Artificial Pneumothorax	319
Fischer, Emily B.: Further Report on the Kahn and Wassermann Tests of Blood Serum and Spinal Fluid	132
Fitz-Hugh, Thomas, Jr.: Some Practical Points in the Insulin and Dietary Management of Diabetics	288
Goldman, Harry: Clinical Report on Uncommon Rectal Fistulas	262
Gordon, Alfred: Consideration of Familial Diseases of Locomotion	284
Gray, John W.: Cancer Pathology	89
Hagerty, John F.: Cancer of Thyroid	91
Haight, Harry W.: Report of Committee on Health Problems in Education	236
Ill, Edgar A.: Palliation in Cancer of the Uterine Cervix and Cancer of the Breast	243
Isacson, L.: Untoward Results of Intravenous Injection of Sodium Iodide	58
James, W. H.: Clinical Report on a Case of Epidemic Encephalitis	292
Knight, I. Warner: Diphtheria	259
Lathrope, George H.: Recognition of Early Pulmonary Tuberculosis	77
Leonard, Geo. F.: Effect of Freezing on Diphtheria Toxin—Antitoxin Mixtures as Regards Toxicity	228
Lowsley, Oswald Swinney: Preoperative, Operative and Postoperative Care of Patients Suffering From Prostatic Hypertrophy	388
MacAlister, Alexander: Graduate School of Medicine Extension Courses	321
MacDonald, Harry G.: Clinical Report	94
Marshak, Martin I.: Place of the Sanatorium in Tuberculosis Campaign	88
Mitchell, Augustus J.: Presidential Address at Essex County Medical Society	81
Moffat, Barclay W.: Orthopedic Causes of Lower Back Pain	194
Nathan, David: Functional Elements in Organic Nervous Diseases and Other Disorders.....	153
Norman, N. Philip: Food Combinations: An Original Scheme of Eating Based Upon the Newer Knowledge of Nutrition and Digestion	375
O'Hara, D.: Clinical Report on Etiology of Hemorrhagic Fluids in the Chest	293
Pardee, Harold E. S.: Special Indications for Use of Digitalis and Quinidine	84
Park, William H.: Preventive Measures in Diphtheria, Scarlet Fever and Measles.....	211
Parsonnett, Aaron E.: Insulin Treatment of Diabetes Mellitus; Report of Eleven Cases	147
Parsonnet, Aaron E.: Report of Two Cases of Leukemia	225
Pfeiffer, Damon B.: Present Status of Upper Abdominal Disease	179
Pinneo, Frank W.: Manual Artificial Respiration for Resuscitation: Its Indispensable Importance. Roemer, Jacob: Roentgen Ray Therapy in Hemorrhagic Metropathies and Uterine Myomas.....	311
Runyon, Mefford: Expert Testimony: Presidential Address	249
Satterlee, G. Reese: Focal Infection in Relation to Pulmonary Tuberculosis	396
Sheehan, J. Eastman: Removal of Stenson's Duct from the Right Antrum by Plastic Methods, and Its Mechanical Counterpart	128
Sherman, Elbert S.: Committee Report on Standardization of a Degree of Disability in Industrial Eye Injuries	361
Sinnott, Martin J.: Treatment of Diabetes	206
Stewart, W. Blair: Gastro-Intestinal Cases as Studied During 29 Years of Practice in Atlantic City	357
Summerill, J. M.: Clinical Report on a Case of Epidemic Encephalitis	16
Teimer, Theodor: Maternal Welfare Program	292
Von Hofe, Frederick H.: Anorexia in Early Childhood	394
Whiteside, George W.: Enforcing the Medical Practice Act	55
Wolfs, Jean F.: Cancer of the Bile Passages.....	254
	93

INDEX

B

BOARD OF TRUSTEES—	
Report of Meetings	269, 301

BOOK REVIEWS—

Annual Report of Council on Pharmacy and Chemistry—Am. Med. Association.....	July, xvii
Clinical Laboratory Methods—Russell Landrum Haden	April, xvii
Diagnostic Methods—Herbert Thomas Brooks	May, xvii
Diseases of the Skin—Richard L. Sutton....	Mar., xx
Elements of Scientific Psychology—Knight Dunlay, Mar., xviii	Mar., xviii
Form and Functions of the Central Nervous System—Frederick Tilney and Henry Alsop Riley, Jan., xvii	Jan., xvii
Habitual Constipation—Ismar Boas, translated by Thomas L. Stedman	Feb., xix
Hernia—Leigh F. Watson	May, xvii
Internal Medicine—James C. Wilson.....	Mar., xviii
International Clinics—Henry W. Cathel.....	Feb., xix
Life Insurance Examinations—Frank W. Foxworthy	Dec., xvii
Manual of Gynecology and Pelvic Surgery—Roland E. Skeel	Aug., xvii
Mental Disorders—Francis M. Barnes, Jr., April, xvii	April, xvii
Obstetrics for Nurses—Charles B. Reed....	April, xviii
Principles of Bacteriology—Arthur A. Eisenberg, July, xvii	July, xvii
Rhus Dermatitis—Pathology and Chemotherapy—James B. McMair.....	July, xvii
Selected Essays on Orthopedic Surgery—Newton M. Shaffer	July, xix
The Human Testis—Max Thorek.....	Aug., xvii

C

CLINICAL REPORTS—	
A Case of Epidemic Encephalitis—J. M. Summerhill and W. H. James.....	292
Etiology of Hemorrhagic Fluids in the Chest—D. O'Hara	293
Gangrenous Diverticulitis of Cecum—Harry G. MacDonald and Donald A. Curtis	94
Uncommon Rectal Fistulas—Harry Goldman	262

COMMITTEE REPORTS—

Health Problems in Education	236
Hospital Standardization.....	171, Dec., xvii
Standardization of Degree of Disability in Industrial Eye Injuries	206

COMMUNICATIONS—

Dr. Olmstead's Letter on Annual Meeting.....	141
Dr. Eagleton's Call to Attend Annual Meeting...	168
Dr. Eagleton's Travel Letters	327
President Eagleton's Letter to Senators Edge and Edwards	109

D

DEATHS—	
Allen, de Luca, Lida Taylor	112
Bleyle, Herman Conrad	145
Bogardus, Henry J.	374
Bowman, J. Floyd	40
Broderick, John J.	145
Cornwell, W. Leslie	304
Craven, Joseph J.	112
Davis, Mrs. Henry W.	113
Doran, John G.	145
Dougherty, Arthur Coles	41
English, David Combs	336
Fox, Mrs. William W.	374
Grim, Frank S.	239
Haines, Eleanor	209
Hollingshead, Enoch	112, 142
Holt, Luther Emmett	73
Hood, Bruno	273
Husted, Joseph M.	209
Husted, Joseph M.	239
Joy, Percy A.	145
Kipp, Charles J.	70
Lampson, Mortimer	304
Lowerree, Thomas W.	336
Madden, Edmund H.	41
Millspaugh, Daniel T.	304
Mooney, John J.	209
Pollard, William M.	209
Prickett, Elmer D.	112
Rafferty, Peter P.	374
Rafferty, Peter P.	273
Reading, George Evans	239
Rogers, George A.	145
Rohn, John Philip	177
Romine, George L.	145

Shipp, William H.	239
Smith, Anna Louisa	145
Soule, Robert E.	209
Tirico, Antonio B.	405
Townsend, Samuel Cyrus	273
Underwood, Mrs. Charles F.	73
Welch, George T.	304

DISCUSSION OF PAPERS—

Gastric and Duodenal Ulcer—	
Edmund J. Ill	5
Clarence A. Hofer	5
J. B. Morrison	5
Charles W. Crankshaw	5
Discussion of Artificial Pneumothorax—	
Alexander Armstrong	321
M. J. Fine	321
Discussion of Artificial Respiration—	
R. R. Sayers	315
Daniel Stroock	316
F. R. Haussling	317
Mefford Runyon	317
A. J. Mitchell	317
Daniel Stroock	317
F. W. Pinneo	318
Discussion of Food Combinations—	
Martin I. Sinnott	387
Gastro-Intestinal Cases—	
Robert H. Rose	20
N. Philip Norman	21
William B. Olmstead	22
Tom Williams	22
Henry B. Costill	24
George Huston Bell	24
Gorden K. Dickinson	24
W. Blair Stewart	24
Insulin in Diabetes—	
Theodore Teimer	150
Asher Yaguda	150
Julius Levy	150
Andrew Rados	150
Rostow	150
Palliation in Cancer of Uterine Cervix and of Breast—	
Francis R. Haussling	247
J. Thompson Stevens	248
Shields	248
Edgar A. Ill	249
Roentgen Ray Therapy in Hemorrhagic Metropathies and Uterine Myomas—	
Ernest A. May	252
J. Thompson Stevens	253
Edward J. Ill	253

E

EDITORIALS—

Academy of Medicine of Northern New Jersey..	36
A. M. A. Annual Meeting	233
An Appreciation	325
Are Our Legislators Mere Politicians?.....	141
Circumstances Attending Illness of Dr. English..	363
Commitment of the Insane	400
Conference of Secretaries—A. M. A.	298
County Societies	399
Director of School Health	107
Doctors and the Public	168
Dr. Kipp's Memorial	68
Dr. Mercer's Resignation	233
Dr. George T. Welch	298
Dues for 1924	35
Editorial Responsibility	168
General Practitioner	366
Happy New Year	35
Indemnity Insurance	233
In Memoriam—David Combs English	363
Journal Volumes XX. and XXI.	35
Medical Defense and Indemnity Insurance.....	201
Medicolegal Expert Testimony	400
Mental Disorders Are Civilization's Greatest Foe	202
Message from the Editor	365
New Jersey Press Association	365
Nonpayment of Dues	70
Not the Editor's Fault	233
Original Petition of Our Society for Extension of Charter in 1915	234
Our Annual Meeting	233
Our Associate Editors	67
Our County Societies	67
Our New Leader—Dr. Lucius F. Donohoe.....	267
Our Members' Vacation	297
Our Officer's Vacations	267
Our Society's Needs	297
Plans for an American Hospital in Japan.....	202
Professions and the Press	108
Psychiatric Institute	143

INDEX.

Publication Committee Rules	267
School Health Program Bill	68
The New Editor	364
The Presidential Address	365
Unworthy Practitioners	201
Who Is Healthier—The City or Country Baby?	326
Work on Bill No. 159	107

EDITORIALS FROM OTHER JOURNALS—

All Must Be Served (Ohio State Med. Jour.)....	267
Assault on Jersey Standards of Medicine (Newark Evening News, Feb. 25, 1924)	111
Burial (Boston M. & S. Jour.)	299
Business Men and Medicine (Boston M. & S. Jour.)	300
Character Building (Chicago Dept. Health).....	203
Compulsory Health Insurance (Illinois Med. Jour.)	69
Curbing the Quack (N. Y. Tribune, Aug. 28, 1924)	327
Danger of Chiropractic (New York Tribune)....	39
Deaths from Diphtheria in Family of Chiropractor (Jour. A. M. A.)	238
Doctor of the Future (N. Y. Times, Oct. 16, 1924)	366
Don't Study Medicine, German Doctors Urge (Illinois Med. Jour.)	299
Do Quacks Really Do Harm? (Critic and Guide, Mar., 1924)	169
Etiologic Study of Anesthetic Death (Tokyo Med. News)	39
For Whom Shall We Vote? (Texas State Jour. Med.)	269
Hear! Hear! The Truth (New York Times, Jan. 13, 1924)	69
Heroes of War and Peace (Rhode Island Med. Jour.)	299
Informing the Public (Bulletin A. M. A.)	170
Lawyers Would Bar Alienists (Nation's Health)...	203
Lay Control of Medicine (Indiana Med. Jour.)....	38
Lay Education (N. Y. State Jour. Med.).....	108
Lay Education Committee Begins Concrete Work (Illinois Med. J.)	175
Long Medical Training versus Short Drugless Courses (Newark News, Mar. 7, 1924)	174
Medical Diseases—Pneumonia (Am. Jour. Surg.)	268
Medical Journalism (Jour. Indiana Med. Assoc.)...	70
Medical Legislation (Indiana Med. Jour.).....	202
Mrs. Jessica Henderson versus President Coolidge (Boston Med. & Surg. Jour.)	204
No Need of Doctor's Speeding (N. Y. Tribune)	204
Nonsensical Chiropractic Twaddle (Newark Evening News, Mar. 17, 1924)	173
Only One Board Needed (New York Times)....	72
Overburden of County Hospitals (Newark Evening News)	111
Passing of Great Men in Medicine (J. Iowa State Med. Soc.)	37
Periodic Health Examinations (N. Y. Med. Jour.)	176
Physicians Need Imperturbability (Osler's Aequimitas)	174
Pregnancy Following Menopause (Critic and Guide)	263
Portrait of Yourself by a Life Insurance Actuary (N. B. V. E. Jour.)	238
Progress in Medical Education (Jour. A. M. A.)	298
Promised Cure for Cancer (Boston Med. & Surg. Jour., May)	203
"Quacks" and "Real Doctors" (New York Times)	108
Rest for the Tuberculous (Boston M. & S. Jour.)	300
Say It with Votes (Atlantic Med. Jour.).....	142
Service and Self (Presbyterian Magazine).....	203
Smoking and Blood Pressure (Jour. A. M. A., Sept. 1, 1923)	39
Surgeon Sued for Performing Operation Without Patient's Consent (Federation Bulletin)	205
The Cancer Cure (N. Y. Tribune)	303, 304
The Doctor's Conscience (Atlantic Med. Jour.)...	38
The Greatest Therapeutic Nihilist (American Physician)	40
The Mirror (Colorado Med.)	301
The Need (Am. Child Health Assoc.)	268
They Are Not Doctors (New York Tribune)....	69
They Claim Too Much (New York Tribune)....	110
Too Lazy (Southwestern Med.)	39
Too Many County Societies Sleeping (A. M. A. Bulletin)	143
Tragedy of Quacking and Procrastination in Cancer (Bull. N. Y. Dept. Health)	204
Typhoid Precautions (N. Y. Tribune)	271
Value of Expert Testimony; Protest of a Layman (Boston Herald)	266
Why Not a Bonus for the Doctor's Labor (Illinois Med. Jour.)	69
Writers of Medical Papers (Boston Med. & Surg. Jour., June 28, 1923)	36

ERRORS—

In Report of Dr. Park's Address.....	296, 327
--------------------------------------	----------

H

HOSPITALS AND SANATORIA—

Alexian (Elizabeth)	176
All Soul's (Morristown)	209, 208
Ann May Hospital (Spring Lake)	239
American (London)	144
Association of Life Insurance Medical Directors..	405
Beth Israel (Newark)	176, 304
Bergen County Hospital	304, 333
Bonnie Burn	40, 209, 273, 304, 336, 405
Bridgeton	176
Burlington County (Mt. Holly)	208
Christ's (Jersey City)	144
Cooper	73
Dover General	73, 208
Elizabeth General	208
Englewood—School for Nurses	239
Essex Co. Homeopathic	208
Greenville	40
Hospital for Crippled Children, Philadelphia....	272
Hospitals in New York and Brooklyn	273
Jersey City	111
Linn Memorial	40
Memorial (Morristown)	208
Monmouth Memorial	73
Mountainside (Montclair)	208
Muhlenberg	73
Newark City Hospital	65, 209
Newcomb Memorial	40
New York Post-Graduate Medical School	405
New York Skin—Cancer	405
Orange Memorial	144
Orthopedic (Orange)	209
Overlook (Summit)	144, 209
Perth Amboy Training School	176
Rahway Hospital	304
Salem County Memorial	111
Soho Isolation	176
Somerset	40, 73, 239, 272
South Orange Convalescent	40
State Hospital, Morris Plains	239, 272
State Village for Epileptics (Skillman, N. J.)....	209
St. Peter's (New Brunswick)	73, 177, 209
Trudeau	177
Union County Isolation	111
Verona	73, 144

M

MARRIAGES—

Corwin-Richman	145
Baker-Powers	273
Brody-Sokoloff	273
Casserman-Boyd	304
Cohen-Myneman	209
Dwyer-Dunn	239
Golstein-Wessel	374
Spalding-Davenport	374
Wood-Assman	374
Wrightson-Johnson	405

MISCELLANEOUS ITEMS—

A Consumption Preventive	303
A. M. A. and Prohibition	265
Bureau of Venereal Disease Control	301
Campaign Against Cancer	38
Case of Unusual Susceptibility to Iodin.....	265
Certified Milk	144
Chemical Foundation Wins.....	April xx
Cystin Calculi; a Complex Surgical Problem....	293
Follow-up Records of a Series of Patients with Bronchopneumonia	294
Infantile Paralysis	301
Infrequency of Tabes Dorsalis in Siam	34
Injuries of the Hands and Feet	336
International Clinic Tour	164
Menace of "Medical Mills", National in Scope..	33
New Conquests of Disease Endorsed by an Authority	205
New Remedy for Syphilis and Sleeping Sickness..	335
New X-Ray Tube for Cancer	334
Our Costly Glands	302
Parent and Offspring	34
Pernicious Vomiting of Pregnancy Treated with Glucose and Insulin	264
Plant Research Fund	April, xxiv
Premature Cesarean Section	335
Proof of the Constitutional Nature of Cancer	335
Rockefeller Foundation Gives Millions	40
Roentgen Diagnosis	336
Spleen Index in Malaria	Oct., xx
Suppurative Otitis Media Treated by Zinc Ionization	335
Syphilitic Heart Disease	335
The General Practitioner	34

INDEX.

Thyroid Gland Emerging from Obscurity	34
Treatment for Cancer	324
Treatment of Psoriasis	336
Tuberculosis Cure in a Worm	34
Volstead's First Aide; The Nimbus Bat	Feb., xvii
Young Doctors Wanted	202

N

NEW AND NONOFFICIAL REMEDIES—

Afenil	Jan., xv
Allergens-Squibb	May, xxv
Antipneumococic Serum	Aug., xx
Apothesine	May, vii
Bacillus Acidophilus Therapy	July, xxvii
Benzyl Fumarate	Sept., xv
Butesin	Jan., xv
Butesini Picrate	May, xviii
Butyn Ointment	Sept., xv
Calcium and Guaiacol Intravenously for Tuberculosis	Oct., xxix
Canine Rabies Virus	Aug., xx
Carbon Tetrachlorid	Aug., xxiii
Chologogues	Oct., xix
Citrophan	July, xiii
Cryogenine	July, v
Cod-liver Oil-Squibb	June, xxvii
Corpus Luteum-Lederle	April, vii
Council Report on New Preparations—Jan., xv; Feb., v; Mar., vii; April, vii; May, vii; June, xxvi; July, v.	
Deodorized Kerosene-Mertz	June, xxx
Dessicated Thyroid-Wilson	July, v
Dibromine	May, xviii, xxvi
Digalen-Roche	Sept., xx
Digifolin	Aug., xx
Diphtheria Antitoxin Globulin	Jan., xv
Diphtheria Toxin-Antitoxin	Oct., xix
Edible Gelatin	May, xxiv
El Zair	Feb., xviii
Epinephrine-Wilson	April, xix
Ergot Aseptic	Mar., xxii
Ethaneset	Feb., xx
Ethylene	July, v
Fat-Free Tr. Digitalis	Aug., xix
Femassin	Aug., v
Flumerin (H. W. & D.)	April, vii
Glycerinated Vaccine Virus	Jan., xv
Gly-So Iodinate	Oct., xxii
Gonococcic Vaccine	Jan., xv
Hay Fever Prophylaxis (P. D. & Co.)	June, xviii
Holocain Ointment	Oct., xix
Iletin (Insulin-Lilly)	July, v
Insulin and Ketosis	Aug., xxv
Insulin-Stearns	Sept., xx
Intraviv	Mar., xxii
Lactic Acid-Producing Preparations	Feb., xviii
Lederle Antitoxins	Dec., xxvii
Liposan	July, xxi
Loeflund's Malt-Soup	Mar., xxii
Mead's Cod Liver Oil	Sept., xv
Mead's Powdered Protein Milk	July, ix
Medicinal Dyes	Nov., xix
Merk's Preparations	Sept., xxvii
Mercurochrome 220	Dec., xxiv
Meroxyl	Dec., xxvi
Metaphen	Dec., xxvi
More Misbranded Nostrums	Oct., xxviii
Neoparsphenamine-Mallinckrodt	July, v
Neutral Acriflavine-Abbott	Sept., xv
Nicomors	Oct., xxix
Nonspecific Protein Therapy	Oct., xxxiii
Normal Horse Serum	May, xviii
Nuga-Tone	July, xxi
Oleo-Bi (Roche)	Sept., xv
Ovidine	Nov., xx
Ovarian Residue-Lederle	April, vii
Parathyroid Gland Therapy	July, xxvii
Patch's Flavored Cod Liver Oil	May vii
Petrolagar	Sept., xxi
Pituitary Tablets-Armour	June, xxx
Pituitrin "S" (P. D. & Co.)	June, xxx
Pollen Allergen Solutions-Squibb	July, ix
Pollen Antigen-Lederle	July, ix
Pollen Extracts-Arlco	May, xxvii
Potassium Bismuth Tartrate	Mar., vii
Procin-Epinephrin Ampules (Abbott)	June, xxvii
Promonta	Aug., xxv
Rabies Vaccine	Nov., xx
Radium and Radium Examinations	July, xxiii
Sagrotan	June, xxvii
Salvarsols and Insulols	Oct., xxxii
Scarlet Red Sulphonate	Mar., xx
Silica in Tuberculosis	July, xxiii
Silver Nitrate Sol. in Capsules	Jan., xv
Silver Salvarsan	Oct., xix
Sodium Morrhuate in Tuberculosis	Aug., xix

Spahlinger Treatment for Tuberculosis	Mar., xxviii
Squibb Preparations	Nov., xix
Sterile Ampules (Swan-Myers)	Dec., xxvii
Substitute for Heroin	Nov., v
Sulpharsphenamine-Mertz	Sept., xv
Suprarenal Preparations	Dec., xxx
Tersul-Hiller	Aug., v
Thiosinamine	Nov., xx
U. S. Standard Vaccines	May, vii, xviii
Vehicles for Prescriptions	Aug., ix and xiii
Vitalait Bacillus Acidophilus	May, vii
Whittington's Consumption Cure a Fraud	Oct., xxxiii
Whole Ovary-Lederle	April, vii

O

ORIGINAL ARTICLES—

A Method of Preventing the Removal of Tonsils and Adenoids and Its Usefulness in Treating Nose and Throat Defects—Arthur E. Ewens	25
Anorexia in Early Childhood—Frederick H. von Hofe	55
As Others See Us—William B. Cutts	157
Cancer Pathology—John W. Gray	89
Cancer of Thyroid—John F. Hagerty	91
Carcinoma of the Bile Passages—Jean F. Wolls	93
Complications of Diabetes in Patients Under Insulin Treatment—Robert Emmet Allen	115
Consideration of Familial Diseases of Locomotion—Alfred Gordon	284
Digitalis as a Stimulant—Louis Faugersers Bishop	183
Diphtheria—I. Warner Knight	259
Effect of Freezing on Diphtheria Toxin-Antitoxin Mixtures as Regards Toxicity—John F. Anderson and Geo. F. Leonard	228
Enforcing the Medical Practice Act—George W. Whiteside	254
Expert Testimony: Presidential Address—Mefford Runyon	396
Importance of Early Diagnosis of Pulmonary Tuberculosis and Physical Signs by Which Such Diagnosis is Obtained—Warren H. Fairbanks	50
Focal Infection in Relation to Pulmonary Tuberculosis—G. Reese Satterlee	128
Food Combinations: An Original Scheme of Eating Based Upon the Newer Knowledge of Nutrition and Digestion—N. Philip Norman	375
Functional Elements in Organic Nervous Diseases and Other Disorders—David Nathan	153
Further Report on the Kahn and Wassermann Tests of Blood Serum and Spinal Fluid—John F. Anderson and Emily B. Fischer	132
Gastro and Duodenal Ulcer—Fletcher F. Carman	1
Gastro-Intestinal Cases as Studied During 29 Years of Practice in Atlantic City—W. Blair Stewart	16
Graduate School of Medicine Extension Courses—Alexander MacAlister	321
Importance of Early Diagnosis of Pulmonary Tuberculosis and Physical Signs by Which Such Diagnosis Is Obtained—Warren H. Fairbanks	50
Injuries of the Eye—William Earle Chase	189
Insulin Treatment of Diabetes Mellitus; Report of Eleven Cases—Aaron E. Parsonnett	147
Interesting Case of Pernicious Anemia—Clarence L. Andrews	224
Local Anesthesia: Its Merits and Limitations—Max Danz	348
Manual Artificial Respiration for Resuscitation: Its Indispensable Importance—Frank W. Pinneo	311
Maternal Welfare Program—Theodor Teimer	394
Neurasthenic Abdomen—Wm. Edgar Darnall	53
Oration in Surgery: The Control of Cancer—A Problem of Education—Joseph Colt Bloodgood	307
Orthopedic Causes of Lower Back Pain—Barclay W. Moffat	194
Palliation in Cancer of the Uterine Cervix and Cancer of the Breast—Edgar A. Ill	243
Place of the Sanatorium in Tuberculosis Campaign—Martin I. Marshak	88
Preliminary Study of Antibody and Relationship of Streptococcus and Bacillus Coli Groups—John F. Anderson and Emily B. Ellinger	56
Preoperative, Operative and Postoperative Care of Patients Suffering from Prostatic Hypertrophy—Oswald Swinney Lowsley	388
Present Status of Upper Abdominal Disease—Damon B. Pfeiffer	179
Prevention, Rehabilitation and Medicolegal Aspects of Sprained Back—John N. Bassin	217
Preventive Measures in Diphtheria, Scarlet Fever and Measles—William H. Park	211
Presidential Address to Alumni Association of Albany Medical College—Marcus A. Curry	221
Presidential Address—Essex County Medical Society—Augustus J. Mitchell	81
Presidential Address of Wells P. Fagleton	337
Prostatic Hypertrophy—Louis L. Davidson	281

INDEX

Recognition of Early Pulmonary Tuberculosis—George H. Lathrope	77
"Reform Diet" in Ophthalmic Practice—George Huston Bell	6
Removal of Stenson's Duct from the Right Antrum by Plastic Methods, and Its Mechanical Counterpart—J. Eastman Sheehan	361
Report of Two Cases of Leukemia—Aaron E. Parsonnet	225
Rhinoplasty from an Artist's Standpoint—Louis P. Berne	121
Röntgen Ray Therapy in Hemorrhagic Metropathies and Uterine Myomas—Jacob Roemer	249
Sinus Thrombosis—Talbot R. Chambers	151
Some Practical Points in the Insulin and Dietary Management of Diabetics—Thomas Fitz-Hugh, Jr.	288
Special Indications for Use of Digitalis and Quinidine—Harold E. S. Pardee	84
Surgical Treatment of the Sequels of Pneumonia—George Blackburne	155
Symptomatic versus Radical Treatment of Infectious and Toxic Neuralgia, Neuritis and Allied Conditions—Pellegrino A. D'Acerno	185
The Musings of a Stomach—Gordon K. Dickinson	13
The Undernourished or Subnormal Child—Sydney Chayes	43
Timing of Insulin Doses—Frederick M. Allen	223
Transuterine Inflation or the Rubin Test—James L. Cobham	215
Treatment of Diabetes—Martin J. Sinnott	357
Treatment of Pulmonary Tuberculosis by Artificial Pneumothorax—M. J. Fine	319
Treatment of Sinusitis—E. Ross Faulkner	75
Tuberculosis in Childhood—Murray H. Bass	124
Untoward Results of Intravenous Injection of Sodium Iodide—L. Isacson	58
Why the Public Consult the Pseudo Medical Cults—Edward J. G. Beardsley	275

P

PERSONAL NEWS—	
42, 74, 114, 146, 178, 210,	
July, xxii, 274, 306, 336, 374, 406	
Committees Appointed for 1924-25	235
New Members Reported	204, 235
Officers Elected at Annual Meeting, 1924	235

PUBLIC HEALTH NOTES—

Annual Audit of Health	113
Auscultation in Pulmonary Tuberculosis	242
Anti-Diphtheria Vaccine in Paris	114
Blindness in Babies, Stamped Out in Chicago	42
Bugaboo of High Blood Pressure	274
Calcium Treatment of Tuberculosis	334
Can Leprosy Be Cured	Oct., xxvii
Clean Milk	Nov., xxvii
Clean Milk	146
Compensation for Occupational Diseases	274
Conserving Health of Pennsylvania's Children	242
Crippled Children's School	178
Danger Signals on Road to Health	178
Deaths in England and Wales	241
Declaration of Geneva; Save the Child	333
Decrease in Contagious Diseases	177
Delay in Using Diphtheria Antitoxin	74
Diabetes, Death Rate	42
Disease Prevention in Bergen County	210
Does Faith Healing Heal?	334
Duringer, the Wonderful Discoverer	241
Epidemic of Vaccination	273
Expert Assistance for Health Work	178
Future of the Health Officer	41
Health Education and Community Uplift	74
Health Officers' Meetings	146
Health Suggestions for Summer	242
Hospitalization of Syphilis	305
Infant Death Rate in U. S.	41, 241
Kissing Dangerous	178
League of Nation's Health Committee	210
Legislation	146
Less Deaths from Alcoholism	113
Life Insurance Companies Interested in Venereal Disease Control	305
Light, Sight and Safety	334
Makes the Weak Strong	273
Measles Germ Found	74
Medical School Inspection	241
National Disease Control Measures	114
Naught to Record	305

Newark Health Report, 41, 113, 146, 177, 210, 241, 273	
New Director of Public Health—Henry B. Costill	374
New Epidemic in Japan	334
New Jersey Death Rate, 41, 73, 113, 177, 210, 241, 273, 305	
New Jersey Health Reports	210
New Mercurial Formula in Septic Conditions	334
New Methods for Prevention of Scarlet Fever	373
Nutrition Problems of Children	113
Permissive and Mandatory Health Laws	334
Physician, as Health Advocate	42
Pitfalls of Practice	274
Public Health Society—of 20 Nations	178
Quack Advertising Barred	178
Rabies in New Jersey	305
Rehabilitation	241
Report of International Health Board	306
Scarlet Fever at Westmont	74
School Children, Health Education of	42
School Health Law	71
Septic Infections Following Childbirth	74
Small-pox in Elizabeth	146
States Bar Alien Physicians	274
Strength of the Nation	274
Summit Health Report	73
Treatment of Simple Goiter	335
Typhoid Death Rate, Low Record	42
U. S. Death Rate	73
Vaccinate All Pittsburgh	273
Veneral Disease Division Activities	178
Virulence of Germs in Corpses	241
Whole Time County Health Officers	146
Worry and Sleepless Nights	241

S

SOCIETY REPORTS—

COUNTY MEDICAL SOCIETIES:

Atlantic	59, 401
Bergen	28, 59, 95, 134, 196, 199, 229, 367, 402
Burlington	60, 367
Camden	28, 95, 368
Cape May	95, 196, 369
Cumberland	60, 160, 296, 369
Essex	60, 161, 402
Gloucester	61, 403
Hudson	29, 61, 96, 134, 161, 196, 369, 403
Mercer	62, 229, 371, 404
Middlesex	30, 135, 229
Monmouth	62, 100, 229, 404
Morris	30, 136, 230, 332
Ocean	404
Passaic	31, 63, 100, 161, 371, 404
Salem	31, 100, 161, 372
Somerset	136, 161, 197, 372
Sussex	405
Union	64, 161, 372
Warren	265, 373

LOCAL MEDICAL SOCIETY REPORTS:

American College of Surgeons	200
Atlantic City Hospital Staff	162, 197, 232, 296, 401
Bayonne Med. Society	31, 64, 101, 136, 198, 271
British Association for Advancement of Science	200
Camden City	402
Jersey City Hospital Staff	101, 198
Middlesex County Recreation Council	197
Middlesex Tuberculosis League	164
Montclair Associated Physicians	64, 163
Newark Academy of Medicine	33, 66, 109, 140, 164
Newark Beth Israel Hospital Clinical Society	102, 137
New Jersey Sanitary Association	232
Philadelphia County Medical Society	139
Psychiatric Institute, Morristown	137
Rutgers Medical Club	33
St. Barnabas' Hospital Staff	100
St. Michael's Hospital Staff	101
Summit Medical Society	32, 64, 199

STATE BOARD OF MEDICAL EXAMINERS—

Antiquack Legislation in New Jersey	33
Report of	114, 145, 239, 305
The A. M. A. and State Medical Licensing Boards	33
Veteran Chiropractic Decision	205

W

WELFARE COMMITTEE—

Meeting Reports	Jan., v, 71, 143, 236, 269, 401
-----------------------	---------------------------------

Journal of The Medical Society of New Jersey



Published on
the First Day of Every Month

Under the Direction
of the Committee on Publication

Vol. XXI, No. 1

ORANGE, N. J., JAN., 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

GASTRIC AND DUODENAL ULCER; MEDICAL TREATMENT AND SURGICAL INDICATIONS.*

By **Fletcher F. Carman, M.D.,**
Montclair, N. J.

The conditions known as gastric ulcer has been recognized by the medical profession as such for about one hundred years, and to Cuivaheil must be given the credit of its identification. Among gastro enterologists, and those seeing many patients complaining of gastric distress, with a history of a year or more duration, the presence of an ulcer as an underlying factor, is becoming more generally accepted, the words "dyspepsia" and "indigestion" many times being synonymous with ulcer.

Although physicians recognized, for nearly a century, that the surface of the stomach was a prey of localized ulceration, resulting in a destruction of tissue, it has only been of recent years that intelligent scientific medical treatment has been possible, and a condition that was formerly thought largely surgical has now become considered a disease lending itself to medical procedure. By the foregoing we do not mean to convey the thought that surgery has not its place in the treatment of ulcers of the stomach, as we all recognize that, in many cases, there are distinct limitations on the medical side, and clean-cut indications for the surgeon's care.

Many different theories as to the etiology of gastric and duodenal ulcer have been advanced, but only a few of the more important ones will be here enumerated. Trauma in its different aspects,

internal and external, chemical and thermal, would seem to stand first among the causative factors. Lessened blood supply, due to a small embolus or nerve constriction of a circumscribed area or a generally anemia, are contributing causes. Focal infection playing its part must not be overlooked, and to Rosenow must be giving full credit for pointing the finger in this direction. Personally, we think that some form of trauma results, which injures the mucous membrane, thereby lessening its resistance to the gastric juices, a condition of auto digestion taking place, plus infection, together with the destruction of the tissue and the formation of an ulcer. After the breaking down of the tissue, this raw surface is continually bathed and further irritated and acted upon by the gastric secretions, of which hydrochloric acid in differing strengths is an important factor. The mechanical irritation, due to the presence of food, and the muscular activity of the organ itself, also play their part in the progress of this condition.

An ulcer of the stomach may be of various sizes, from one no larger than a pin point, which is hardly discernible, to the saddle ulcer occupying a comparatively large area. The ulceration may be single or multiple—one ulcer may be present on the stomach wall, and another in the duodenum. We have a case in mind, in which at operation the duodenal ulcer was found, but one on the lesser curvature was overlooked. An ulcer may be superficial in type, or again it may penetrate with much destruction of tissue and be surrounded by large infiltration. The process, if not arrested, may perforate into the abdominal cavity, with peritonitis promptly resulting. In the process of tissue destruction, a blood vessel of considerable size may be eroded

*Read at the 157th Annual Meeting of the Medical Society of New Jersey, at Atlantic City, June 22nd, 1923.

and an alarming hemorrhage result, the blood being vomited to a large extent in stomach ulcers, and in the duodenal type, passed by the bowel.

The site of the ulcer is usually in that portion of the stomach which sustains the greatest amount of irritation, and trauma—the lesser curvature—increases in frequency toward the pylorus. At least 75 per cent. of gastric ulcers occur in this location. Although most frequently found on the lesser curvature and near the pylorus, no portion of the stomach is entirely exempt; ulcers of the anterior and posterior walls are, therefore, more apt to be overlooked because of their position, than those situated in other parts of the organ.

The duodenal ulcer is most frequently found within an inch, or inch and a half, of the pylorus, being probably caused, to a large degree, by the irritation of the highly acid chyme as it is expelled through the pyloric outlet.

The peptic ulcer may be either acute or chronic in type. If the former, the symptoms develop rapidly, and instead of a history of a long and continued gastric difficulty, it may be of only a few weeks' or months' duration.

The methods used as aids to diagnosis, as viewed by the author, and their relative importance, are: first, the carefully taken history; second, a thorough physical examination; third, x-ray, which includes a fluoroscopic examination; and fourth, the gastric analysis of the test meal.

The symptoms, though seemingly classical, are so frequently modified by other conditions; as for example, chronic appendicitis and cholecystitis, that diagnosis is, many times, most difficult. Pain or distress in varying degrees is the most prominent symptom and is usually the cause of the patient seeking relief. This distress is described as burning, gnawing or boring in character, and usually occurs in a definite cycle in relation to the taking of food. The time element in this cycle is due to the location of the ulcer. If near the cardiac orifice, the pain occurs almost immediately after eating; if near the pylorus, one or more hours may elapse before its onset. The duodenal ulcer is also distinguished by this element of time, in that usually three or four hours elapse after the taking of food, before distress is experienced; and it is the fact of this greater period of freedom

from distress which causes these patients to eat so enormously. Eating relieves their pain—"hunger pain" it has been called—for three or four hours, which induces the patient to eat every time he begins to feel a return of discomfort. In other cases where the distress comes on shortly after eating, the patients often become afraid to eat, and will omit one article of diet after another, thereby eliminating, as they imagine, that which his "disagreed" with them. Because of this restriction, as well as the disturbed digestion, emaciation takes place, the patient often losing considerable weight.

The distress which is caused by the taking of food is due, no doubt, to the secretion of hydrochloric acid and its irritating effect on nerve endings of the ulcerated surface, as well as to the mechanical effect of the food itself, plus the muscular activity of the stomach. Often, after the condition has existed for a considerable time, the pain, instead of being general epigastric in character, becomes localized and a more or less tender spot, corresponding to the site of the ulcer, may develop. Besides the taking of food, pressure may increase the discomfort and the wearing of tight corsets and belts is often impossible. To relieve pressure, a patient with an ulcer on the posterior wall of the stomach may find that the knee chest position is the most comfortable, and assume it on all possible occasions. Those in which the anterior wall is involved, find their greatest comfort lying on the back, hence the position assumed is often of much assistance in localizing the lesion.

Vomiting, which occurs in a fairly large proportion of cases, may be voluntary or involuntary. If voluntary, the patient has discovered that emptying the stomach brings relief, and the finger in the throat or other method is often resorted to. On the other hand, the involuntary vomiting is brought about by the extreme irritation of the contents of the stomach, or where an obstruction exists in the pyloric area, to a accumulated ingesta and over-distension of the stomach. Bleeding which occurs to a lesser or greater degree in most ulcers—chronic and acute—can most often be demonstrated in the feces in the form of occult blood, and in all suspected cases the patient should be restricted to a meat-free diet, and its presence sought. If large in amount, the blood may be vomited as bright red or

"coffee ground" in character, or passed by the bowel, bright or black in appearance, depending upon the length of time elapsing before its passage. Careful observation, we believe, would disclose the presence of blood in the feces in at least 70 per cent. of all cases of gastric and duodenal ulcers.

The X-ray, while of prime importance in competent hands, is not infallible, yet has become of increasing help as an aid to diagnosis. The x-ray should be used only as "an aid to diagnosis" and not, as too often resorted to, as the whole diagnosis. As has been stated it is not infallible, since the human element is there to a large degree in technique and interpretation. In fact, we believe the the x-ray finding should be disregarded if it is negative, where the other findings are positive, and the patient should be treated for ulcer. Too many times, we are sorry to say, the Roentgenologist is depended upon to make a quick and easy diagnosis for the lazy practitioner.

The gastric analysis of the Ewald meal is of great value, and we employ it as a routine measure. The amount of acidity, while not to be depended upon as of diagnostic importance—as we now know that ulcers may exist in the presence of low acid content as well as in one that is high—yet by this means much valuable information is obtained, particularly in after care and treatment of the case. The acidity, both free and total, gastric motility, the presence of blood, lactic acid, or a condition of achylia, are some of the points of information gained. If a condition of hypochlorhydria or achylia exists, a Wassermann examination is particularly indicated.

Among other diagnostic helps must be mentioned the string and tape tests. In both of these the procedure is the same, the patient swallowing, when the stomach is empty, either the string or tape, which after remaining in situ for several hours is withdrawn and carefully examined for blood stains. A single thread or tape test would not be accepted as positive evidence of an ulcer, but upon repeated tests a blood stain, if found at approximately the same location, would form very strong presumptive evidence.

As has already been mentioned, focal infection, having been almost universally accepted as one at least of the causative agents of gastric ulcer, it is of prime im-

portance that before beginning active treatment for the condition, all sources of infection should be eliminated; and to that end the teeth and tonsils should receive careful attention. With the progress of knowledge and experience of more recent years, we are now able to treat medically a large percentage of gastric ulcer cases, with success.

Among the methods of treatment, there are two which stand most prominently and are based upon logical and scientific lines and their respective values have been well proven. The author has in mind the duodenal tube devised by Einhorn, and the alkalization of the stomach as advanced by Sippy. We think that not one alone should be used, but a combination of the two—the duodenal tube plus alkalization is the ideal method of procedure, and many cases so treated have responded with very gratifying results.

With the duodenal tube, the stomach is put as nearly as possible at physiological rest, passing as it does from the exterior of the mouth to the third portion of the duodenum, the tube remaining in situ for the entire period of the treatment of from three to six weeks. The patient becomes accustomed surprisingly soon to its presence. The tube in place, the alkalinity of the stomach is maintained by the regular use of magnesium oxid and sodium bicarbonate, the amount used depending upon the amount of hydrochloric acid to be neutralized. Under the treatment the patient soon loses all traces of his former distress, which amounts at times to almost agony, and after the first twenty-four hours we find an entirely different expression of the face. Where we had one of pain and suffering we now see one of comfort and contentment.

With the stomach at rest we can now proceed to treat the ulcer. The bismuth subnitrate which we use in one dram doses once a day is brought into contact with the ulcerated surface, as also is the nitrate of silver given in $\frac{1}{4}$, or $\frac{1}{2}$ grain doses in $\frac{1}{2}$ ounce of distilled water once a day. Belladonna is also given in the form of the tincture, principally to lessen gastric secretion and spasm. The amount used depends largely upon the amount of acidity to be overcome and spasm present, but we usually find that five to ten minims given three times a day is sufficient.

The feedings given are of peptonized

milk, five ounces; lactose, four drams; and melted butter, three drams; given through the tube by the drip method every three hours from 6 A. M. until 9 P. M. When indicated, strained orange juice may be given through the tube once a day. Because of the absence of hydrochloric acid in the stomach, such patients have no sense of hunger, but enjoy instead a feeling of well-being, and are even unconscious of possessing such a thing as a stomach. When the alkalies, as used, do not keep the bowels active enough, or when there is much intestinal gas formed, a daily enema of plain warm water, at body temperature, is used.

After the removal of the tube, the patient is placed upon a milk diet for the first twenty-four hours, being given five ounces every three hours, followed after each feeding by the alkalies. The second day he has a tablespoonful of well-cooked cereal added three times a day. The third day he receives two tablespoonfuls of the cereal and a creamed vegetable soup. Soft eggs, well cooked, mashed vegetables, toast or zweibach, milk puddings, chicken, lamb and fish are gradually added during the second week.

It has been the author's practice to have his patients report in person after leaving the hospital, once a week for two months, and then at less frequent intervals for at least a year; the patient being impressed with the idea of the necessity of a carefully selected diet; the penalty for non-observance too often being the formation of another ulcer.

The question may be suggested "What about reoccurrences?" and I would answer that, with the treatment already outlined, a recurrence, or more properly speaking, a secondary ulcer, is a rarity, the reason being that the treatment is carefully followed up and the diet supervised for at least a year. The patient meanwhile is warned that the condition which brought about the first ulcer, recurring, might cause a second one.

Before considering the surgical aspect of the peptic ulcer the writer wishes to state that, it is his opinion that all gastric ulcers should have the benefit of a well thought-out medical treatment, thereby greatly reducing the number necessitating the care of the surgeon. On the other hand, the physician in his treatment should be ever vigilant to recognize the point where medical procedure ends and surgery begins. As, for example,

when the case does not progress in a normal manner; when the pain and discomfort do not disappear in a reasonable time, and when the frequent laboratory examinations of the feces do not show a diminishing amount of occult blood—which should be entirely absent in from two to three weeks. The foregoing are danger signals which must be recognized as such, and their presence continuing, prompt surgical assistance should be summoned, as we may be dealing with an ulcer plus a malignancy.

Case Report.—Patient age fifty; physician of good physique. Gave a history of eight months' gastric distress. Discomfort would begin about two hours after eating, consequently would take something, milk or malted milk every two hours. If making calls would ask for a glass of milk at patient's home. X-ray examination confirmed the diagnosis of ulcer, a penetrating ulcer of the lesser curvature near the pylorus, was seen. Entered the hospital and duodenal tube feedings and alkalization treatment were given for three weeks. No relief from distress was experienced unless alkalies were given every two hours, the presence of occult blood in feces remaining constant. At the end of three weeks another x-ray examination was made and the ulcer not showing any progress in healing, the patient was operated upon and three ulcers were disclosed on a malignant base.

It has been the authors experience that stenosis of the pyloric outlet, resulting in gastris retention, when caused by an ulcer, will usually relax and ultimately disappear when treated as already outlined. The cases which do not yield should be immediately operated upon, if a favorable outcome is anticipated.

The acutely hemorrhaging ulcer which was formerly thought to be a surgical indication, can, in our opinion, best be treated medically, plus transfusion, as this type of case is often considered a poor surgical risk. The ulcers which show a tendency to recur, or cause secondary ulcers to form a short time after medical treatment, should be given the benefit of surgery.

In conclusion, permit us to enter an earnest plea for a better understanding and a more conservative treatment of gastric and duodenal ulcers, and thus allow the patient, the "party of the first part," to preserve his stomach, one of

the most important organs of the body, intact, as the Great Creator intended it should be.

DISCUSSION

Dr. Edward J. Ill, Newark.—I am very glad the doctor has written on this subject, and done it so well. We are coming back and leaving to surgery cases that need it. There has been entirely too much surgery on the stomach. Such work as Dr. Carman is doing is helping the matter along very considerably indeed. Ever since Virchow showed that ulcer of the stomach was due to embolism, we have come to understand that we must remove such causes as produce embolism. Whether these cases are cured by medicine or by surgery, Dr. Carman has very well drawn our attention to the fact that these cases must remain under observation for a long while. Because a patient has had an operation for ulcer of the stomach does not mean that he may leave the hospital and live on pork and beans or corned beef and cabbage. This idea is carried along very commonly at the present time. Dr. Carman very distinctly said that for a year or more after medical treatment the patient should remain under the doctor's care. Dr. Carman also drew our attention to the general clinical aspect. I wish he had said a little more on the differential diagnosis. The differential diagnosis is often difficult in ulcer of the stomach. There are other forms of difficulty which stimulates it. Take the ordinary hyperchlorhydria in the excitable business man or in the woman who is overtaxing her nervous system. Those cases get well by other means. They get well by general rest, proper surroundings, cheerfulness, and so on. When the doctor gives the milk by the Einhorn tube, does he limit the patient to thirty ounces of milk a day, besides the butter? Thirty ounces of fluid a day is a comparatively small amount of fluid to give a patient. We can give that in certain forms of cardiac insufficiency for a short length of time, but not for a long time, such as is needed for gastric ulcer treatment. The amount of fluid should be a great deal more in gastric ulcers. Possibly he gives fluid by other means than just by the tube. I want to again compliment the doctor on the excellency of his paper, and I am glad to say that surgery is finding its proper place gradually.

Dr. Clarence A. Hofer: There is just one thing about gastric ulcer that the general practitioner is up against, and that is to keep his patient and most particularly to keep the friends of his patient from meddling with the treatment. As Dr. Carman says, it is a long drawn out issue and these patients get a little better and a little worse. They come to you and perhaps after a month or two they commence to tell you that "my friend, Mrs. So-and-So suggested I do so and so;" and many times before they go to the gastro-enterologist they have been to half a dozen other doctors and none of them seem to be able to hold them. Of course, the gastro-enterologist does hold them better because he is a specialist and they have a little confidence in him; but there are some of them that it is absolutely impossible to hold, on ac-

count of their friends. I remember a case I had one time, a woman, and the third time I saw her, I said to my assistant, "that woman is not going to stay for treatment; there is somebody back of it." After questioning her at some length, I found it was her husband. I said, "you bring your husband to the office the next time you come." She did, and I talked to her husband for about half an hour and told him that this was a case that required a great deal of treatment; I told him all about the diet, the amount of work that the woman had to do, and the general care of his wife. I think I saw the case three times afterwards. There was another thought that occurred to me: Sometimes when you send your patients to the surgeon, they don't always do the work that is indicated. I had a case where a man had a stomach ulcer in the posterior wall; there was absolutely no retention, no obstruction of the pylorus. The indication was excising the ulcer. The man went to the Mayo Clinic, got cold feet, and came back and was operated on by a local surgeon, who did a gastro-enterostomy. The gastro-enterostomy was not indicated at all; it could not possibly have done the man any good. The man suffered a good deal more after the operation than he did before. Finally, he went back there and Dr. Jardick excised the ulcer and found the man had a chronic appendicitis. I know the surgeon was competent to do an appendectomy. The man made an absolute recovery.

Dr. J. B. Morrison, Newark: I wish to add my congratulations also to the doctor for his excellent paper. The medical treatment of these cases is not carried out frequently enough. There are two points I wish to stress. The first is the length of time we keep these cases under observation following the treatment, or operation. I have in mind a case where for five years after a gastro-enterostomy the patient had no symptoms. Then the man lost his wife, his home was broken up and he took his meals in restaurants. The symptoms of ulcer returned, but under special dietary treatment, he is doing well. The other point I want to lay stress upon is the length of time we keep these patients in the hospital. Four or five weeks under constant observation and intelligent treatment is necessary for relief. During the first few days, until tolerance for the tube is established, the caloric value of the food intake is so low that the patient should not be allowed to take any exercise. He should be treated in bed. As Dr. Ill has said, it does not seem to me that the amount of fluid suggested by Dr. Carman is sufficient. I carry it up to two or three quarts. In some cases where the tube is not well tolerated, then absolute rectal feeding for five days, followed by a diet of peptonized milk for ten days, and after that selected soft foods for a month, gives excellent results.

Dr. Charles W. Crankshaw, Newark.—I enjoyed the doctor's paper very much, and having been a sufferer myself from duodenal ulcer for some years prior to 1911, I can appreciate the fact that the symptoms he gave were classical and I was glad to hear him stress (as I knew Dr. Ill would) the value of the

after care. You have to be especially careful of the diet for at least a year. I observed that faithfully and I know what it means. In 1911 I was operated on and I haven't known since that I had an ulcer, thanks to my friend Dr. Ill.

Dr. Carman, closing: Concerning the fluid we give through the tube. I do not mean to convey the idea that was all the fluid the patient got, because we give water by the mouth, also as well as through the tube as per indication.

"REFORM DIET" AS A THERAPEUTIC MEASURE IN OPHTHALMIC PRACTICE*

By George Huston Bell, M.D., F.A.C.S.

Attending Ophthalmic Surgeon, New York Eye and Ear Infirmary
New York

Diet should be the first thought and greatest consideration in the life of an individual.

In presenting my paper to you on my "Reform Diet," I wish it to be understood that it is part and parcel of my remedy for the "Three T's." The ramifications of the "Three T's" (teeth, tonsils and toxemias of the Intestinal Tract) are so interwoven that to my mind it is impossible to disassociate them. In thinking of any one of the "Three T's" in connection with a patient, the other two invariably come to my mind. They go hand in hand. All patients ought to be given the "acid test" for the "Three T's."

We know that gastro-intestinal disturbances and severe septic intoxication, are at times brought on, or aggravated, by oral sepsis, diseased tonsils, or wrong food combinations, and not infrequently by all three. I said at the A. M. A. meeting in 1919, that oral sepsis was one of the greatest menaces to the human race! I now wish to reaffirm that statement here this evening. I also said that negative evidence does not exclude the possibility of infection from the tonsil, and that bacteriological examination of all removed tonsils which I have examined, demonstrated the presence of organisms, and I have been driven to the conclusion that a healthy tonsil is a scarce article. There is no doubt in my mind that the constant swallowing of infected secretions from the mouth and tonsils, is one of our greatest sources of danger, and in addition

to this, septic infection may be absorbed into the circulation from both, and thus diseased teeth and tonsils in two ways become an enemy of the host and knaw at the vitals.

E. Libman,² in a paper on Acute Bacterial Endocarditis before the British Medical Association said: "The important thing is to systematically rid all patients having valvular disease, of the ascertainable foci of infection" (teeth and tonsils, etc.) and he further adds that the question of prevention seems to be the most pressing. Behan,³ in a paper before the American Medical Association said: "We see continually in our private dispensary and hospital work, all the changes characteristic of albuminuric neuro-retinitis in varying combinations. In the absence of nephritis we do not hesitate to ascribe as a cause for these changes the "Three T's" of Bell, the anemias and infectious diseases." Olmstead⁴ said: I feel safe in saying at this time, excepting trauma and venereal disease, we can or will eventually prove every diseased condition of the eye, due to some one of the three recognized sources of focal infections—viz. "The Three T's." In the light of all this, what is the sense and what is the use of putting patients on a diet, unless you are going to get rid of infected teeth and diseased tonsils? We *must* attend to the hygiene of the mouth and throat.

We now come to my "Reform Diet." I hold and believe that diet is common sense applied to living. All must agree to that, if we are to make any real progress in overcoming toxemia. We must consider the fuel that we put into the laboratory that nature maintains in the stomach. The day is at hand when the progressive ophthalmologist must take up with his patients the question of diet. How many oculists here this evening warn their patients against excessive consumption of sugar, sweets and starches, and wrong food combinations. Many ophthalmologists are so occupied with the purely ophthalmological aspect of a case, that they pay absolutely no attention to the practical important etiological factors.

When we realize that ninety out of one hundred persons die from some secondary disease, the result of some focal infection, then it is certainly high time that we all were studying the causes of focal infections. When McCollum⁵ comes out in his latest book on "The Newer Knowledge of Nutrition" and says that no one will be likely to dispute the statement that few

*Read before section "On Ophthalmology" at the New York Academy of Medicine, October 16th, 1922 and at the 157th Annual Meeting of the Medical Society of New Jersey, at Atlantic City, June 22nd, 1923.

people are entirely well, and that their fail-ures, indiscretions, fits of temper, tendency to complain, their lack of enthusiasm, their inefficiencies as creatures, are in a great measure the result of ill health, and he adds that there can be no reasonable doubt but that the diet may deviate from the optimal even in the United States, to a degree which can easily cause the results we see. Now if what McCollum says be true, and I believe it is, and we have been living on a so-called well-balanced diet which includes meat, bread, vegetables and sweets, and also meat, potatoes, vegetables and sweets, and heavy starches and proteins at the same meal, I think then it is high time we are making a change, and that we tried some other form of diet, and thus endeavor to prevent the factors concerned in the production of this formidable array of ills, of which McCollum speaks. Hence my reason for presenting to you for consideration my "Reform Diet," as a therapeutic measure in ophthalmic practice. Let us keep a few things clearly in mind. Heavy starches and proteins must not be eaten together at the same meal; for the reason that starches are digested in the mouth and intestines, and proteins in the stomach. Then, if that be true, what is the sense of eating food together that fights in the stomach? Why not eat them separately, and at different meals?

When meat is eaten it causes a flow of gastric juice. The elements of a food that are peculiarly fitted to a certain digestive fluid, cause this fluid to be secreted,— so that when meat and highly starchy food are eaten together, the meat will be digested in the stomach, but not the starch. Now all the time the starch is in the stomach, it is not only not permitted to be digested, but it also hinders the digestion of the protein of meat. So we get an acid fermentation in the stomach from the starchy foods with the formation of volatile and non-volatile acids and sometimes marsh gas, hydrogen and alcohol. It is the acid fermentation produced by these wrong food combinations which in the end lead to toxemia. Starchy foods, of course, we need for energy and heat, but they must be eaten with non-starchy vegetables, salads and fruits, in order that they may all pass out of the stomach at the same time, and in that way we are able to prevent acid dyspepsia and acid fermentation in the stomach.

Matthews⁹ in the third edition of his "Physiological Chemistry" says that

starches, or carbo-hydrates, are digested by the ptalin of the saliva, the amylopsin, maltase and lactase of the pancreas, and the invertin of the intestinal juices, so that they are all reduced to a state of monosaccharids. He further adds that some of the carbo-hydrates are further broken up by the bacteria with the resultant formation of lactic acid, alcohol, marsh-gas, hydrogen and butyric acid. Sherman⁷ also adds that among cases of excessive bacterial decomposition in the digestive tract, the fermentation of carbo-hydrates with the production of organic acid, and possibly with alcohol, is most likely to occur in the stomach while putrefaction of proteins occurs mainly in the large intestines. Then if what Sherman and Matthews say be true, why not eat carbo-hydrates at a time when they won't be detained in the stomach? Sir Francis Hare⁸ comes out flatfooted, and says (in "Food Factor in Disease," Vol. I.) that there is nothing in the stomach to digest the starches. J. H. Tilden⁹ in his first "Volume of Food," says the same thing, and has advocated for a long time this diet of not mixing starches and proteins at the same meal. Deeks¹⁰ also has pointed out that there is nothing in the stomach to digest the sugars.

I am a firm believer in the baneful effect of sugar as a systematic poison in diseased conditons of the eyes. We all have seen the baneful effect of candy and sweets in children coming to us with eczematous conjunctivitis, one of the commonest diseases of the eye. Sugars and sweets should be tabooed at all times, and really belong to the vanities of life. Stay away from sugars and sweets and get the necessary sweets by eating fresh fruits and vegetables. There is no doubt but that sugar and starches are the chief causes of dental caries, and a train of toxic symptoms. One hundred years ago the total per capita consumption of sugar in the United Sates was less than nine pounds per annum. Since then it has increased by leaps and bounds, until now this country is probably the largest consumer of sugar in the world.

Kellogg and Taylor estimated the per capita use of sugar just before the war, at close to four ounces a day per individual. Estimates of sugar in the blood are of value in the treatment of all cases of obscure eye conditions. Chace said in 1920 at the annual meeting of the Medical Society of the State of New York, that sugar is perhaps responsible for producing more hyperacid-

ity than any other single article of diet and that the great increase in the prevalence of hyperacidity during the last decade is largely due to the increased sugar consumption.

There is a growing demand for a scientific supervision of the diet in health and disease, and an increasing realization of its importance. Hence my great interest in "Dietary Reform." I want to emphasize the importance of using certified raw milk, and of eating raw fruits, green vegetables and salads. Again, certain important substances occur in animal fats which should form a part of the diet, such as fats from meats, butter and cream. We should consume at least one quart of milk or its equivalent in dairy products every day, and raw food and raw fruits should be eaten as salads and desserts once or twice daily to insure the required amount of vitamins. It seems that in the course of cooking or drying something essential is destroyed. We ought every day to eat freely of some leafy vegetable food such as spinach, cabbage, beet tops, brussels sprouts, lettuce dandelions, pepper-grass and swiss chard. They have unique properties. The consumption of these leafy vegetable foods will go far towards overcoming constipation.

I have so arranged the "Reform Diet" that milk can be taken at the proper time. I am a firm believer in the food value of milk and when it is pure and clean it is article of food for infants and children, and its value is being more and more appreciated by adults. Milk is such an important food, that I must describe it more in detail. With regard to the milk question, Funk was the first to suggest the relationship between the composition of the milk, and some deficiency diseases in children. Funk stated that on heating milk certain vitamins become more or less completely destroyed. Therefore great advantage lay in the consumption of a certified raw product, adequately safeguarded from contagious diseases and containing a more or less constant fat content. Milk taken with the ordinary meals frequently causes catarrh. Why? Because of overeating and overloading the stomach. Some people take milk with their meals just as if it were water, not realizing that one pint of milk contains 320 heat units and 18 grams of protein are added above what is necessary. Milk must be taken with a starch or fruit, and not with a full meal, because one quart of certified raw milk is a meal in itself.

Recently I had a grand example of an overloaded stomach from taking milk like water with meals. This patient was a hearty eater, and drank about two glasses of raw milk with each meal, three times daily. This crowding of nutrition developed a catarrhal state which was followed by intestinal Toxemia which was in its turn followed by a keratitis of both eyes. Upon looking him over for the "Three T's" I found that his tongue was heavily coated, his breath was very foul and his urine was loaded with indican, also he was a sufferer from constipation. The odor of the breath is often a significant index of the blood condition. When it is offensive it is, to me, always suggestive to toxemia. His teeth were apparently sound and healthy. I was able to extrude pus from his tonsils. Examination of his eyes showed that the patient had Mooren's Ulcer of right eye and incipient ulcer of the left." There was no question about the diagnosis in this case. The ulcer in the right eye developed from the margin of the cornea above, and had extended all the way around the cornea. The gray cloudy margin of the ulcer was undermined and could be elevated. Moreover there were marked inflammatory complications. He had been treated for six weeks by an ophthalmologist from another State. I should add that this oculist had cauterized the ulcer with carbolic acid several times and had used the actual cautery, also hot fomentations and atropine were being used. All I did for him was to have his tonsils enucleated at once, put him on my "Reform Diet" with hot applications to his eyes—bichloride vaseline—1-5000 in both eyes night and morning, and atrophine solution in his eyes occasionally; while his colon was thoroughly emptied every day by means of an enema of water at blood heat. This patient made a good and rapid recovery and was able to return to his native State in two weeks where he continued the treatment for four weeks more. Dr. H. A. Wakefield of Charlotte, North Carolina brought this patient to me, and in a letter from him recently, said that Mr. B. now had normal vision in both eyes.

Rules of the "Reform Diet."—The principle of the "Reform Diet" is simple and very plain. Not to mix heavy starches and proteins at the same meal.

Heavy starches: Bread, whole wheat, white corn or rye, and crackers. Potatoes, rice, macaroni, corn, lima beans, dry beans, and also sugar.

Line "A"

Heavy proteins: Meats of all kinds, fish, shell fish, chicken, duck, turkey, eggs and cheese.

Nothing above line "A" must be eaten with anything below line "A." I have arranged a "Diet Sheet" for my patients and my clinics. Anyone who does not like my combination may make up his own just so long as he does not violate the rule and principle of the "Reform Diet." This system of diet which I can strongly recommend, is in no respect a radical one. It includes the best features of several types of diet. Eat any kind of food you like or choose, provided you eat it at the right time.

McCollum¹¹ says that in the last century changes in the habits of the population of Europe and America, have brought about changes in diet. The changes have been in favor of highly milled cereal products, muscle meats, potatoes and sugar. *This diet is a failure* in animal experimentation and is proving a failure in human experience. Evidence that this is true is abundantly supplied in the percentage of under-weight children in our schools and in the prevalence of rickets, small jaws, and teeth which are irregular, poorly developed and which decay easily. Personally I am convinced that there is something wrong with our way of living. McCollum has proved it with animals, and my experience with this "Reform Diet" over a period of years, in my clinics and with my private patients, coincides exactly with his findings. It is a never ending fermentation in the stomach and putrefactive condition in the intestines, brought about by wrong food combinations, bad teeth, and diseased tonsils, that is destroying the human race. We must not lose sight of the fact that toxemia ranges in intensity from an ordinary cold to severe acidosis. And also do not forget that we can have excessive fermentation as well as excessive putrefaction in the same individual and at one and the same time. Sherman, in his latest book on "Chemistry of Food Nutrition" adds, that from eating large quantities of meat and sugar together, a type of fermentation ensues in which oxalic acid is produced and which must be highly injurious and most distinctly toxic. Also Lieb¹² has proven that oxalic acid is produced in the colon by the bacterial decomposition of sugars and that oxalic acid

produces definite toxic symptoms even in small amounts.

Exclusive Use of Faulty Foods which are low in vitamins, prevails largely among many civilized people at the present time. Funk was the first man to give us light on the vitamin content of our food, which is essential to the proper nutrition of the body. McCollum and Simonds have proved keratomalacia (or this peculiar form of ophthalmia) to be due specifically to lack of fat, Soluble A-Vitamin in the diet of animals. Bloch of Copenhagen adds greatly to our knowledge of ophthalmia in cases of infants due to incorrect diet. Bloch¹³ has observed during a period of five years, 40 cases of keratomalacia among children fed on highly contrifuged milk, fat being given in the form of vegetable margarine. A cure was obtained in most cases with the aid of raw milk or cod liver oil. Bloch believes that this form of ophthalmia occurs quite frequently in Denmark and may often be a cause of blindness.

McCarrison¹⁴ states that this disease occurs not infrequently in India from a diet of polished rice and vegetable oils, and is curable with cod liver oil. I have observed only five cases of keratomalacia, all five in young children. The diagnosis is easy: All of them were suffering from severe malnutrition. The skin was dry, shriveled and scaly. Raw milk and cream, with the addition of cod liver oil, affected a cure in three of the cases.

Headaches and Dizziness Due to Food Intoxication.—The following is a most interesting case and was unquestionably due to "wrong food combinations." This patient Dr. G. F. R., a friend of mine, consulted me for occipital and frontal headaches which came on from time to time. He also complained of great dizziness without loss of appetite. In fact he said to me "I am so dizzy that I can't properly do my work." Upon examining his eyes I found that his glasses were correct. Looking him over for the "Three T's" I found his teeth excellent, his tongue coated, and his tonsils had been removed. Then I took up with him the question of diet, and this is what he was eating every day:

Breakfast—Orange juice, cooked fruit with sugar and cream, eggs and bacon, or fish, coffee, toast or muffins. 11.30 A. M.—Egg-nog.

Luncheon, 1 P. M.—A big bowl of thick soup, (meat) with lentils, beans and peas,

black bread and butter. 4.30. P. M.—Arrow root biscuits and two cups of tea.

Dinner, 7 P. M.—Soup, meat, potatoes or rice, or macaroni and cheese, fresh vegetables, salad with French dressing, and a sweet dessert.

He was especially fond of puddings. The diagnosis was easy in this case. I at once told him that he was suffering from intestinal toxemia due to wrong food combinations. This was brought about by eating starches and proteins at the same meal, and overloading the stomach. He is a very busy dentist and he thought the more he ate, the better he could work. In other words he was catering to his appetite. I put him on my "Reform Diet". The patient has been following this diet now for twelve months. His dizziness has entirely disappeared, and his headaches have been completely relieved. He says that he feels like another man. He is as fine as a fiddle, and works from 8.30 A. M. to 6 P. M. six days a week. It is easy to follow cause and effect in this case—I hold and believe that in this age of abundant starch and imperfect mastication, the stomach and intestines are flooded with undigested starch which give rise to many evils, and this is especially true when starches and proteins are eaten together.

We now come to chronic congestive and non-congestive Glaucoma, the cause of which is little understood. We must not lose sight of the fact that Glaucoma is not merely a local disease. From my standpoint chronic Glaucoma is the outcome, in every instance, of prolonged chronic auto-toxemia, provided we can exclude syphilis, and we may have both infections in the same case. All Glaucoma cases must first have the Wassermann test. A vitiated blood supply not only acts deleteriously upon the nervous apparatus, but coincidentally with this, gives rise to inefficiency of the secretion of every endocrine gland in the body, the natural consequence being an absence of healthy cell metabolism, and the dire disturbance which must follow. My experience teaches me that chronic constipation, gout, rheumatism, arterio-sclerosis or uricacidemia, or all of them exist in those who become the victims of chronic Glaucoma. A recent communication from Professor E. Fuchs¹⁵ in Archives of Ophthalmology says that the relation between Glaucoma and thyroid is supposed to be due to the influence of the gland on the salt metabolism. In Glaucoma cases, the salt in the

blood amounted to 0.72% as against 1.13% in healthy persons. Also Irme got good results according to Fuchs by thyroid treatment in Glaucoma cases and he found the tension lower during pregnancy when the thyroid becomes enlarged. I said here at the New York Academy of Medicine, four or five years ago, that fewer of our chronic simple Glaucoma cases would come to the operating table if we would only remove their focal infections and the profound toxemia from which they all suffer. Lagrange comes out in his latest book and lays stress on a point that is often forgotten, namely that Glaucoma is generally not merely a local disease, but an ocular disease occurring in an already diseased organism. My conviction is that Glaucoma must be treated constitutionally, as well as locally or surgically. I have records of twenty-two cases of chronic simple Glaucoma which I am treating according to my method and so far not one of these twenty-two cases has yet come to the operating table. One of these cases has been under observation for nearly ten years. In all my cases I use nitrate of pilocarpine. The eye stands it better over a period of years, and I think it is less irritating. Posey first called my attention to it and as Posey says, the drug must be used constantly and continuously every day at least three times. The history of this patient whom I've had for ten years is very interesting. At the time I first saw her, she was 70 years of age. She complained of disturbed vision, as though looking through a fog, and the street lamps had a halo of colored rings. She had recently been in the hands of two oculists, both of whom had made a diagnosis of chronic Glaucoma. Both oculists wanted to operate upon her. When I first saw her, she had a distinct Glaucomatous disc in each eye; her anterior chamber was very shallow, with the pupils moderately dilated. Schiotz recorded 35 m. m. of Hg. in each eye. Her blood pressure was 180. Her urine was loaded with indican. Upon looking her over for the "Three T's" I found that her tongue was heavily coated, her breath foul, and she suffered from constipation. X-ray of teeth negative. She gave a history of consuming considerable sweets, and was in the habit of eating twice daily and taking a great deal of coffee, (about three or four cups a day.) First of all I restricted the use of the eyes for close work, and put the patient on a diet. The exclusion of heavy meats and stimulants

such as tea, coffee, alcohol and tobacco is most essential in order to obviate the final need of surgery in these Glaucoma cases. E. Lyman Fisk¹⁹ says that it is a poor compliment to the human race to say that life is unlivable without alcohol, tobacco, coffee and tea. Also with this patient I used pilocarpine nitrate, one per cent. three times daily, hot bathing for the eyes three times daily, and a hot bath at bed time. I also gave her a vial of bacillus bulgarius three times daily after meals, and careful attention was given to evacuation of the bowels every day. In addition to this the colon was thoroughly emptied once a week by an enema of water at blood heat. This regimen has been kept up for ten years with practically no loss of vision and only a slight impairment of the fields. Is not such a method as this, far preferable to an operation on a patient over 70 years of age?

Let me give one more example of chronic simple Glaucoma which is most interesting. The patient, also a woman, age 45, was operated upon for chronic Glaucoma by one of our well known surgeons. When I first saw her three years ago, I looked at her eyes and saw that she had had a proper operation performed, but the vision remained very poor. She came to me to be treated for headaches, and pain in her good eye. I found the anterior chamber very shallow. The tension was up. Upon looking her over for the "Three T's" the x-ray of the teeth revealed abscesses at the roots of eight of her teeth. There is nothing that can destroy bacterial life in the pus sacs at the roots of infected teeth except extraction, so we had her infected teeth removed. Her tonsils had already been removed. Her tongue was heavily coated, her breath was foul and she was suffering from constipation. Moreover, her urine was loaded with indican. Her Wassermann was negative. I placed her on the "Reform Diet" and the usual treatment for Glaucomatous eyes. I gave her Bacillus Acidophilus. We know that the Bacillus Acidophilus is the protective organism of the intestinal tract. Eggston and Norman²⁰ have proved that beyond question. I give the B. A. for one month at a time, and then I give small doses of iodine treatment, which was first brought to my attention by A. J. Quimby,¹⁸ is so valuable that I must give you the formula:

℞ Iodine crystals, Gr. XXX.
Ammonia iodide, Gr. XX.
Alcohol, 3 IV.

Glycerine, q. s. ad 3j.

misce et sigma: one drop in glassful of water twice daily.

I think for patients who have been traveling the road of toxia for years, and where the toxins have been accumulating in the blood, that small doses of iodine are exceedingly valuable. Under its use the metabolism of the whole body is improved, and the reconstructive forces of the body are substantially increased in power and efficiency. As the result of this treatment this patient has normal vision and normal fields after three years. No effort has been made in this case to improve the quality of the blood stream, until she came under my observation. Of course I operate for Glaucoma when I find it necessary—that is when the treatment which I have outlined is not effective. This, however, is rarely the case. I had a chemical examination of the blood made in six of these Glaucoma cases. In four of the six cases, the blood chemistry showed acid content above normal. The uric acid ranged from 4.5 to 6 mg. per 100 cc. of blood. According to De Niord and Bixby, when the blood chemistry reveals uricacidemia, that is enough to justify a diagnostic finding, indicating a chronic infection somewhere in the body. I maintain that in all chronic simple Glaucomas, we should insist upon a chemical blood test for uric acid.

This *general routine for treatment* which I advocate for Glaucoma cases is also carried out by me in all diseases of the eye, such as episcleritis and deep scleritis, retinitis, optic neuritis, eczema of the lids, herpes febrilis, herpes zoster, oedema of the lids, toxic amblyopia, immature cataracts, both hard and soft, choroiditis, keratitis of all forms, chronic conjunctivitis and blepharitis, irido-cyclitis, plastic iritis, chronic uveitis, recurrent hemorrhage in the vitreous body, sympathetic ophthalmia, angioneurotic edema and papilloedema. Of course, in conjunction with this general routine treatment, the necessary local remedies for the eyes must be used. Salvarsan and inunctions of mercury and tuberculin are also added when indicated and necessary. In chronic conditions of the eye where the tuberculin test is positive, I find myself giving less and less tuberculin, and relying more and more upon fresh air, sunshine, exercise, my "Reform Diet" and the iodine treatment, as well as close attention to the sanitary condition of the colon.

Several well-known oculists have recently

reported cases of choroiditis, keratitis and episcleritis cured as a result of the diet. I have any number of such cases among my records. There is one case of exudative choroiditis in a young Federal Board student, aged 24, of which I would like to speak. History as follows:

The sight of the O. S. was lost in France as a result of shell explosion, O. D. vision 10/200. On examining his eye with the ophthalmoscope there was a large cloud of floating opacities in the vitreous, so thick that the details of the fundus could not be seen. I admitted him to the U. S. P. H. Hospital No. 38 (New York Polyclinic* where the Wassermann was negative. Looking him over for the "Three T's" I found that his teeth were in fine shape, but his tonsils were filled with pus. I had his tonsils enucleated, and put him on the "Reform Diet." Hot applications to the eye for one hour at a time, three times daily, were given and also a weak solution of atropine was used. Careful attention was given daily to complete evacuation of the colon. The patient began to improve, and left the hospital at the end of two weeks with instructions in regard to diet and enemas. Six months later I saw this patient and much to my surprise he had 20/20 vision. On examining the vitreous no floating opacities could be found, but several patches of choroiditis could be seen in the peripheral portion of the fundus.

Conclusions

1. After five years' experience with the "Reform Diet" I feel that I stand on a firm foundation in recommending it as a therapeutic measure in ophthalmic practice.

2. I agree with Meller, who says that sympathetic ophthalmia may be produced by endogenous infection, and he adds that the organisms in the blood settle in the tissues of the eye weakened by injury, the organisms becoming virulent and finally reaching the other eye through the blood stream. I maintain that a house cleaning process is in order in every obscure condition of the eye.

3. Alimentary toxemia is beyond question responsible for a large percentage of diseases of the eye. The relation of food ingested, to alimentary toxemia is very important. Most people eat far too much and might, with advantage eat very much less. This idea should be constantly kept in mind by every ophthalmologist.

4. In acute and chronic diseases of the

eye, would it not help matters materially if we adopt measures, such as "Reform Diet," the systematic removal of ascertainable foci of infection and the closest attention to the sanitary condition of the colon, with a view to removing the toxic condition of the blood?

5. When a man like McCollum comes out in a recent issue of the Journal of the American Medical Association and says that a diet, composed of milled cereal products, muscle meat, potatoes and sugar is a failure in animal experimentation, and is also proving a failure in human experience, then I think it is high time that we "STOP—LOOK—and LISTEN."

REFERENCES

1. Bell, G. H., "Relation of Teeth, Tonsils and Intestinal Toxemias to Diseases of the Eye." J. A. M. A., October, 1921.
 2. Libman, E., "Acute Bacterial Endocarditis." Brit. Med. J., 1920, p. 306.
 3. Behan, J. L., "Fundus Changes in Nephritis." J. A. M. A., June, 1922.
 4. Olmstead, W. D., "Focal Infections in Relation to Eye Diseases." J. Med. Soc. of N. J., June, 1922.
 5. McCollum, E. V., "The Newer Knowledge of Nutrition," 2nd edition.
 6. Mathews, A. P., "Physiological Chemistry," 3rd edition, p. 399.
 7. Sherman, H. C., "Chemistry of Food and Nutrition," 2nd edition, p. 97.
 8. Hare, Francis, "The Food Factor in Disease." Vol. I. p. 41.
 9. Tilden, J. H., "Food." Vol. I, p. 24.
 10. Deeds, W. E., "Gastric Duodenal Ulcers," N. Y. Med. Jour., 1912, p. 1103.
 11. McCollum and Simmonds, "The Potency of Commercial Vitamin Preparations." J. A. M. A., June, 1922.
 12. Lieb, C. W., "Oxalic Acid Production in Colon as in Diseases Causation," N. Y. Med. Journal and Medical Review, June, 1923.
 13. Bloch, C. E., "Eye Diseases and Other Disturbances in Infants from Deficiency of Fat in Food," cited from J. A. M. A., 1917.
 14. McCarrison, R., "Faulty Food in Relation to Gastro-Intestinal Disorder." J. A. M. A., Jan., 1922.
 15. Fuchs, E., "Ocular Manifestations of Internal Secretions." Arch. Oph., July, 1922.
 16. Fish, E. L., "Preventable Diseases of Adult Life," N. Y. State Med. J., Dec., 1921.
 17. Norman, N. P., and Eggstrom, A. A., "A New Technic For Preparation of Bacillus Acidophilus Milk and Its Therapeutic Value." N. Y. State Med. J. and Med. R., June, 1922.
 18. Quimby, A. J., "Physiological Iodine." N. Y. Med. J. and Med. R., Dec., 1922.
- 40 East 41st Street, N. Y. City.

Doctor: "Have you taken every precaution to prevent the spread of contagion in the family?"

Rastus: "Absolutely, doctor, we've done—bought a sanitary cup an' we all drink from it!"—New York News.

THE MUSINGS OF A STOMACH*

By **Gordon K. Dickinson, M.D., F.A.C.S.,**
Jersey City, N. J.

This is a day of strange happenings, for a stomach to be able to voice itself and be understood, speaking in gutturals which have not heretofore been comprehended! Having this opportunity, it gives me great pleasure to talk for my kind and let others know who I am, where I came from, what I have to suffer, and what brings me the most happiness.

I am a little individual all to myself,—I have a mind and a brain and can sense things, but, like the dumb animals I go along about my work and keep mute. Incarcerated alive in a body, I have been told, for many a long year!

Just below me is my twin brother, called the duodenum. We are two pals and work well together. When one of us is disturbed, so is the other. The griefs and ills of one is felt by the other. We are true companions in the life we are living.

Just above me is the great sluggish liver. He is the most moody fellow I ever heard of. He is never happy, never smiles, and is always given to melancholy. He broods sad thoughts and indispositions. Perhaps because he is so easily intoxicated, a little dope makes him spoil his work for the day. Yet he is my mystery.

Alongside of me is the spleen, a cantankerous body. Every now and then he vents his ire upon me by contracting and forcing his secretion in a way to disturb that which I am making. It is said that the blood coming from the spleen does not mix with the blood that passes from me on the way to the liver, that his blood goes to the left side of the liver more largely. This may account for its small size and apparent insignificance. Many eons ago he was flesh of my flesh. I supported him, gave him nourishment and protection. It is the same old story. He became independent and ingracious. It does not pay to help some folks. Rush says that when poor folks get money they get a new doctor.

Down below me is another pal, who seems to want to be in sympathy with me, the end of the large gut, which they call the ceco-appendix. He is happy when

he is playing a "me-too" game. When I want to work, he wants to work. When I am idle, he is idle. If he is disturbed and irritated beyond endurance, somehow or other I am, too, and both of us feel a lethargy. So you see that we are fellows who are bound together, living an independent life. We have a law unto ourselves and are most contented under our own government.

It has long been known, so it is told in the books, that "compassion is in the bowels," that the warm emotions, that which goes to make life comfortable and also that which gives for courage and dominance reside here. The short for sturdy courage is guts, and I am it, and well may it be, for we have existed longer than any other part of the body. Ancestry tells. He who has the longest pedigree, who has buffeted life the longest and yet developed, has the greatest vigor and the least given upsets.

Life began as a stomach. The first organ formed was a stomach. The first Adam was a stomach. This is my ancestry and I am proud to feel that the heart, the lungs, and particularly the brain, came long after me.

The first stomach soon found growing around its outlet and cutting off its connection with his other companions, that which is called the brain. This was a very insolent thing to do, but the brain has always been a dogmatic, conceited, insolent fellow. To protect herself, Nature formed another gut, while she was elaborating something more permanent and satisfactory, necessitated by slowly changing conditions, because the first stomach was in a body that lay in shallow waters on the mud and the time was coming when it would be on dry land under very different surroundings.

So eventually, a new stomach was formed with his associated relatives and pals. Nature never completely destroys her handiwork. What she once made, she keeps for some other purpose, so the first stomach became the third ventricle of the intruding brain, and down through the spinal cord is a minute canal, the fossil of the intestine. The secondary provisional and short-lived gut we now find running through the bones of the spine as a noto-cord.

Nature seemed to anticipate that this fellow brain would undo matters and spoil her plan, so she curiously duplicated conditions existing in me. My upper end

*Read at the 157th Annual Meeting of the Medical Society of New Jersey, at Atlantic City, June 22, 1923.

being but a pouch can be compared to the mouth. It is a receptacle for food, where I retain it until I am ready to grind it with my secretions in my lower portion. Here I imitate the work that should be done by the teeth.

There are glands that send a juice into the mouth that can act on the food very much as my glands do, but there was a time, long, long ago, when two other glands added their juices. These have now become occluded and their substance must come to me through the blood. There are times when I miss it, too, for it was tonic and stimulating, and gave me the zest which is necessary for the best work.

Just above my lower opening, which can be called another gullet, though it is very short, is embedded in me a ring of substance much like the tonsils that straddle the new gullet. Being of the same makeup and nature they are subject to the same troubles.

Before the brain came along to live in his waywardness, only enough food was taken in to meet present demands, but with his advent, desires and pleasure created an uncertainty, so my duties and my makeup were duplicated in the mouth. It does seem funny that the mouth is but another stomach.

But while I and my close friends have been quiescent, doing our work systematically and thoroughly, and, as a rule, uncomplainingly, the brain has been growing and has developed a conceit and a dominance which are mighty disturbing. Up in a dark attic he is a top floor lodger, with the cobwebs of ignorance and the mice of wandering emotion. He wants what he wants and generally gets what he wants. The palate has what he likes, so the old times are passed when proper food came down to me from above by the gullet. It was sometimes dirty, but seldom harmful.

For millions of years we went along in this pleasant way, adapting ourselves to conventional conditions, without being particularly disturbed in our work, but the brain, I believe, invented the cook, and the cook tickled the palate. Then came an influx of so many new things with such strange differences, that even the strength of years could hardly endure them.

The microscope, they tell me finds what people call germs, but I do not need a microscope. Even though the light that

comes to me is subdued and pinkish, I can find them, and nothing is more irritating to me than these new little things, which are being sent my way. Sometimes they come in food, sometimes in the saliva from dirty mouths and bad teeth. I have had the credit of being able to kill anything that comes down, but there is a limit, and many a time I suffer sorely and break out in little blisters, and even here and there become ulcerated because of the constant influx of foul saliva and irritating food.

Then, again, man is careless of getting rid of his refuse. There was a time when there was no such trouble, He worshipped Cloacina, sub Jove Squat, but now the blood which is forced through me very often has a fecal taint, and this is disturbing. It weakens my system, makes my muscles lax, plays the dickens with the liver who has no sense of humor, and I am not able to do good work. Pride is taken from me because of my inabilities and I get sore. All the trouble that I have had come since that fellow brain came along. If I were in the body of a Bassler or Einhorn I might expect to lead a happier life, but I am not, I am simply carried around in the corpus of an ordinary being. If anybody knows anything about the brain, I do.

Doctors think they know something about stomachs, how we feel and the joy we experience in doing our work when undisturbed. We have pride in the fact that no part of the body is as strong and tough as we are. When I relate some of the experiences I have been through, perhaps you will appreciate it.

When the pinkish light first shown through to me, I well recollect having a delightful white fluid come down through the gullet. It was most pleasing to my sense. Involuntarily I embraced it, turned it around and a minute-like wave passed down over me. It was a great satisfaction as I sensed it with touch and action, passing it along to my twin-brother, who told me it was just what he had been waiting for. It was the purest and sweetest of fluids and my chemical sense discovered in it all that was good for the rest of us and nothing harmful.

When the body got to be older, and yet not so very much, I heard a voice saying she was tired of being housed up and a slave to home life, she wanted to mix with society, and why not give it a bottle? So it was agreed that the woman upstairs

should have charge and I should take the chance. Presently down came some whitish stuff, but I soon felt by sense peculiarly mine that it was not the same as I had before. I heard them call it pasteurized milk, but it must have been a little old, perhaps been kept on the window-sill to keep it cool, and I could see lots of little wiggling things in it to which I was not accustomed, and they irritated me. It made me uncomfortable and soured my disposition. This affected the milk and sickened me, and I could not but show my irritation by tormenting the body. At last I got so upset that I spued it out. The good woman became anxious and the parents were greatly worried when they returned home. They sent for a man they called a doctor.

Now came unto me the greatest complication of all, for I have found doctors, (and I have had many of them since), were as much bothered by their brains as I and my ancestors have been bothered by ours. Presently, down from above came a dose of an oily substance. It was very nasty. I immediately rebelled, and what I did not throw on the carpet, I passed as quickly as possible to my brother. I presume you would call this human nature, but I could not help it.

I remember one time when the body was older and the folks left him alone, he got into the closet, helped himself, and down came to me a great mixture of preserves, sweetmeats, and anything else he could grab hold of and what the palate thought was pleasant. There was no consideration whatever for poor me! It was only what pleased the palate, and the change from one tickle to another led to an accumulation various and vicious. I have always liked to be distended: I am not comfortable when I have sufficient to grasp upon. I do my best work when work is given to me, but to overload with nauseous sweets is more than I can stand. Again, my disposition was soured and I am sure that I felt it perhaps unseemingly. I could not very well pass this stuff out immediately and had to make the best of it I could.

Then what a howling time there was! For the tube below commenced to cramp and colic and there was a terrible storm and disturbance. Once more I was the sinner and I had to be dosed for the misery in the nether regions. Down trickled a whitish powder. It did not seem much at the time, but it certainly

did not tend to make one happy. Following this came something I heard them say was a "pusher," and it surely did a great deal of that.

Although we all recovered and peace came at last, we never could decide which was the worse, the jam spree or the doctor. The first seemed to please somebody and the latter only satisfied the family.

There came a time when my encumbrance, or the man I encumber, whichever way you want to call it, through work and worry, particularly the latter, had a great sense of tire. Somehow or other I failed to have that energy which once existed and I could not stir things around. The end of me nearest the gullet, which is never more than a pouch and never was used much for work, distended, and I found that I was dropping down towards the lower parts. Food dilated me, I could not mix it up good, and gases formed. My misery was his misery. They took me to the doctor again, and instead of his thinking about matters, he showed his ignorance of stomachs by demanding an xray immediately.

While this celebrated professor was working, a door slammed. Now I am very susceptible to fright. Nothing weakens me so much as to be frightened. Right away I felt myself drop and almost touch bottom. Just then the man who had the x-ray said there was a ptosis. This led to a great deal of tinkering and treatment. All to no avail, because the doctor did not understand. Fortunately, every lane has a turning, and the time came when they were all tired of doctoring and we got a rest. I became myself again, only to be disturbed in another way.

I began to realize that the fluid coming down from the mouth, which is always coming day and night without interruption, was becoming offensive. There was an unpleasant taste and a continuous inflow of little animals that I have had before in my food. My skin felt the effect. Instead of sending out at regular intervals the juice I enjoy making, I was compelled to coat myself with a slime. This seemed to be the only way in which I could protect myself from this bad stuff. Then my work became insufficient. My secretions could not reach the food and I could not properly digest that which was given me. The irritation was so excessive that I would blister in places. One of the blisters ulcerated, became very pain-

ful and the doctor had to come. He had to have an xray and gave all attention to the ulcer, none or very little to me, and none at all to that above which had been causing all the trouble. But, after a while, after I had been in misery for a long time, they seemed to come to their senses and the body was passed over to a dentist, who then pulled every one of the teeth. This stopped the inflow of putrid stuff, But it added to my trouble by there coming down to me food which had not been prepared. But I lived through it all and managed after a time to obtain considerable vigor and efficiency.

Of late I have heard much talk of death, religion and fads of belief, all of which interests me greatly. I never knew a stomach to die. They are all immortal and were it not for the brain I am certain it could be proven. Carrel has done so, they say. Brain is always talking of religion, which he cannot separate from theology or emotion. Fear of death and the cowardice in him grew his religion. Even I have a kindred emotion, for there is a mystery in the liver which appeals and rather awes me. He is so quiet and dignified that I feel he must have some quality yet unknown. The Assyrians felt so, too, and one of the souls was supposed to reside in it. George Crile is also leaning toward that opinion. Perhaps when the brain is as old as I am, his intellect will be perfected and Death, his special inheritance, may be modified into eternal life.

Man is as his stomach. Treat me kindly, give me three jobs a day, mixed with joy, and the blood will flow to the temples with a sense of body comfort. The cecum and the appendix will contract, the colon be lifted up and its contents sent on. Humor, joy and laughter are my tonics. Gloom and solitude kill. Once I knew a fellow stomach who at home by itself would sicken on mush and milk, but it could go to New York and with music and companionship take good care of lobsters and champagne.

I have had my lesson, never to trust the palate because it is fickle, never to trust the brain because it is selfish, and to feel that the life of the stomach was one uncertainty after another, and I am sure that if the brain and the body and the doctors and the mothers knew that I was but another individual incarcerated alive, ready and willing and thoroughly adapted by Nature to do everything which

is reasonable, stomachs would be happier and the body more comfortable.

Methuselah ate what he found on his plate

And never, as people do now,
Did he note the amount of the caloric count—

He ate it because it was chow.
He wasn't disturbed, as at dinner he sat,
Destroying a roast or a pie,
To think it was lacking in granular fat,
Or a couple of vitamins shy.

He cheerfully chewed every species of food.

Untroubled by worries or fear,
Lest his health might be hurt by some fancy dessert,

And he lived over 900 years!

GASTRO-INTESTINAL CASES AS STUDIED DURING TWENTYNINE YEARS' ACTIVE PRACTICE OF MEDICINE IN ATLANTIC CITY*

By W. Blair Stewart, M.D., F.A.C.P.

Atlantic City, N. J.

Atlantic City is the world's greatest playground and one of America's most important convalescent seashore resorts. The care of her resident population is not unlike that of any other city. The transient visitors offer a slightly different problem. They are here for a day or more and are then on their way touring or returning home. The stimulating action of the change, the pure sea air and the attractive exercises on the only world known boardwalk all combine to produce an appetite entirely unknown to the average person, as well as the soporific influence that leads to pleasant dreams and nights of most refreshing sleep. With such ideal conditions one can readily realize how convalescent patients will over-exercise and, too frequently, forget their dietetic rules and make combinations at the hotel table that so frequently bring them to grief. Not due to tainted, spoiled or substandard foods, but from improper mixtures and too large amounts. Acute, sub-acute and chronic gastro-intestinal troubles predominate during the heated term and are quite in order at other seasons.

*Read at the 157th Annual Meeting of the Medical Society of New Jersey, at Atlantic City, June 22nd, 1923.

It has been the privilege of the writer to practice his profession continuously in Atlantic City, winter and summer, for twenty-nine years. A hasty survey of this period elicits some rather startling changes in health conditions and a material lessening of the acute diseases of the gastro-intestinal tract, particularly among children and babies. Prior to the strict enforcement of food laws and the pure milk campaigns, the advent of summer was sure to bring its numerous cases of cholera morbus, cholera infantum and diarrheas. The old infective types of cholera morbus and cholera infantum have practically disappeared in Atlantic City, and are so rarely seen that they are almost a medical curiosity. Typhoid fever has been so carefully followed in the advancing years that the very few cases treated have been mainly traced to foreign sources of infection. When it was found in past years that the use of shell fish from sewerage infected waters produced much of the gastro-intestinal and typhoid cases, the city authorities, backed by the co-operation of the local medical profession and the State Board of Health, closed all these waters against clam and oyster tonging and the primary source of trouble disappeared never to return.

The source of supply and the local handling of milk have both been so safeguarded, the cream percentage regulated and the bacterial count rendered almost nil, that Atlantic City has one of the purest and safest milk supply in the country. With these facts and a city water that is above suspicion and so thoroughly watched by expert sanitarians and chemists, both summer and winter, that contamination is practically impossible, we can well see why Atlantic City is as healthy as any city in the United States. The Atlantic County Medical Society has always co-operated with the Health Department in maintaining and improving health conditions and sanitation and has traced many sources of infection and recommended ways for their correction. Most of the hotels in Atlantic City have kept their corps of help under medical supervision and have maintained a standard of health for the betterment of all.

Dietetic Studies.—A close study of gastro-intestinal cases convinces one that the largest percentages are due to or have been caused by indiscretions in diet. The average case has been left to flounder for himself on the question of food, except that he has been told to "be careful of what you

eat." Sugar, sweets, coffee and tea are probably the worst offenders. A case of "chronic indigestion" in a young woman aged 28 will illustrate a very common condition. Distress shortly after eating, eructations of gas and heartburn, slight dyspnoea, epigastric tenderness and constipated, very neurasthenic and some loss of weight. Your diagnosis would probably be ulcer, or some organic condition. Careful physical examination is negative. How about diet? She drinks two cups of coffee for breakfast, two cups at noon and two or three cups of tea for her evening meal. Always puts two or three teaspoonsful of sugar in each cup. Eats a plate of cereal for breakfast with two heaping teaspoonsful of sugar. Is very fond of desserts and eats them daily, usually ice cream. Picks at vegetables and meats and likes jellies, syrups or candy. A grand total of twenty-three teaspoonsful of sugar (allowing three spoons of sugar in the desserts and candy) with starches, tea and coffee! What digestion can handle this amount of sugar daily and keep normal? All sugar was eliminated; one cup of coffee with cream allowed for breakfast; meat and green vegetable diet substituted and the case was soon perfectly well. This case illustrates a series of most common, so called, indigestion that has not reached ulceration, but would if allowed to continue.

The combination of shell fish with a salad and sweet dessert is ideal for gastric and intestinal distress or nausea. It is a most common combination at the hotel table and affects many. The common American breakfast combination is grape fruit with sugar, followed by cereal with sugar, a cup of sweetened coffee or tea and meat or eggs. A fruit acid, starch, cream, sugar and tea or coffee—ideal for fermentation, acid eructations and distress. The active hard worker digests it for a time, but the sedentary individual does not. The habit of drinking orangeade, root beer, sweetened sodas, sundaes and other liquid concoctions and liquors, as well as eating candy between meals are causes of indigestions that are too frequently overlooked. The daily use of mustard, catsup, vinegar, spices and other condiments are marked causes. Other cases take too much cream and fats and have intestinal fermentation. Bearing in mind these facts, why jump to the conclusion that our case is organic and must become surgical? If one devotes time to the dietetic study of his case, more than half of

your indigestions can be cured without medication or operation. It is well for us to remember that a diet of sugars and sweets will usually delay peristalsis and lead to constipation. Many of the sedentary cases can not digest starches and sugars as they lead to fermentation and acidity. Pastry, pies and rich desserts, if taken at all, are best digested following the noon meal and then only by those who can take active physical exercise sufficient to consume them. Each case is a law unto itself and should be carefully studied from the dietetic standpoint. "One man's meat, another man's poison" should not always be your motto, but keep it in mind in your treatment.

Physical Diagnosis Versus Laboratory Methods.—The modern short cut to medical diagnosis lies in laboratory methods, fads and empiricisms. Unfortunately present day teaching tends toward majorizing these methods and minimizes the importance of a thorough physical examination. in a well lighted quiet room with the patient properly bared and free of superfluous clothing. A personal contact with patients year in and year out proves the superior advantage of thorough investigation by physical means together with a good case history. In gastro-intestinal cases it is not always necessary to take test meals and make use of the doudenal bucket as a routine. In fact these methods are so far overdone that it is no wonder that many patients come under your care mental and physical wrecks, dreading the next process through which they are to pass. No wonder that we have so many ambulant gastro-intestinal neurasthenics. If the medical colleges of today would make more real practical everyday doctors of medicine, real family doctors, and teach them how to do their own work and rely upon their own powers of diagnosis and treatment, we would hear less of the Osteopath, Chiropractor and get-rich-quick other isms.

It is far from the mind of the writer to neglect laboratory studies of most cases, for many an obscure type can only be cleared by a careful, technical laboratory examination. Rely first upon your own methods and confirm them by the laboratory if needs be. A careful blood, stool or urinalysis and, in exceptional cases, gastric contents, nose and throat secretions and excretions from sinuses or wounds. Patients expect some attention and want some advice to follow while you are making second-

ary investigations. X-ray examinations and translucent light are most important adjuncts and, in some cases, absolutely essential.

No physician should be too busy to take or have taken for him a thorough case history, for in this often lies the essence of fact in arriving at a definite diagnosis. This should be an inflexible rule in all obscure or doubtful cases. Another phase of practice is the follow up system in chronic or acute cases. In this the seashore physician meets his greatest handicap and is unable to tabulate many cases to a finish. Here today and gone tomorrow never to report again.

It is well to remember many possibilities in examining gastro-intestinal cases. How many thoroughly masticate their food? Do they have sound teeth or sufficient approximating molars to grind their food? Pyorrhea, mouth infection, tonsillar infections and sinus troubles all feed poisons into the stomach with resultant local and focal infections. My studies and experience with "indigestions" show a very large percentage of cases from these sources. My feeling is that many gastric ulcers have their origin from improperly masticated and fermenting foods and receive their infection from the poison fed from diseased mouth and throat infections. It is more than plausible. It is interesting to note the large percentage of gall bladder infections and gall stones that show an antecedent typhoid fever as the causative factor. Why not have our typhoids treated to a finish rather than discharge them three-quarters cured with the possibilities of sequelae or sources of infection.

In hunting for trouble we must not overlook the possibilities of intestinal parasites—tape worm, round and small worms, hook-worm and the other numerous varieties. Many so-called indigestions have their origin and perpetuation in these causes. Many of these types are seen in the visitors to Atlantic City from the South and the tropics. The organic and malignant types are constantly consulting us. Every case of abdominal pain is not appendicitis, gall-stones, intussusception, gastric or duodenal ulcer but some may be. We have the same sentiment among the laity at the seashore that appendix cases should wait until they reach home. The only safe course in true appendicitis is immediate operation. In the very few cases in my practice where exploratory incision was made in doubtful conditions, after consultation, only one or

two could be justified. If you can not make a diagnosis yourself and in consultation, after you have resorted to all laboratory and x-ray methods, you are not justified in resorting to blind surgery by the exploratory method. In exception, if you are satisfied that there is a greater probability of saving the patient by surgery than by conservatism, better than submit to surgery.

Errors in Diagnosis.—No one is infallible in diagnosis and our mistakes sometimes teach us valuable lessons. A young woman with every classic symptom of appendicitis and a typical blood picture was operated on for appendicitis. It was found to be perfectly normal. It was a case of acute hemorrhagic pancreatitis with effusion. She recovered in spite of the unnecessary operation. Another embarrassing situation in a young boy whose case, in consultation, was diagnosed appendicitis in acute form showed a normal appendix but had an intestinal knotted mass of lumbracoid worms. Case of a woman, aged 70, developed an acute obstruction of the bowels, not relieved by the usual mechanical means. Diagnosis of probable malignancy of the colon, confirmed by two consultants. Case too far gone for operation. Palliation until death. Autopsy showed an old diverticulum near the cecum and another obstructing diverticulum at the splenic flexure of the colon with an abscess containing about a pint of pus. Another case referred was a flabby emaciated woman, aged 45, with diagnosis of malignancy of the colon. The rectum was found to contain impacted feces. A good nurse, using mechanical means over a period of four days removed enormous quantities of hard, almost solid dry fecal matter with an entire cessation of all symptoms, loss of the anemia and gain in flesh. The mass had disappeared and apparently no cancer was present. The case drifted to another city and has not since been reported. It is not uncommon to mistake an inflamed right tube or ovary for appendicitis. These mistakes should be eliminated by a rectal or vaginal examination. In children it is well to bear in mind that a right lower lobar pneumonia may give symptoms simulating appendicitis and lead to an unnecessary operation. If one makes it a routine to carefully examine the right lung in all cases of appendicitis in children, this mistake should not occur. Another case of a young child that had been treated for a mucus colitis for several months was cured by the removal of a peach stone from

the rectum. Many of our cases of indigestions are undiagnosed ulcer of the stomach or duodenum. There is no more striking statement than that given by McFarland of Philadelphia, when he stated that in every one hundred autopsies made by him in the Philadelphia Hospital, he found on the average one active or healed ulcer of the stomach.

When Do Cases Become Surgical? The large percentage of our gastric and duodenal ulcers heal under medical treatment. If, after a few months or weeks active treatment, your case does not respond and x-ray study shows ulcer present, the case is surgical. All malignant cases may be palliated or even cured by active surgery if not too long delayed. Every case or undoubted appendicitis, acute or chronic, is surgical for safety.

Treatment.—Dietetic treatment has been discussed in another section of this paper. When we come to a discussion of medication, no two will wholly agree. After all, most cases are better cared for hygienically and dietetically than by a multiplicity of medicine and hodgepodge prescriptions. If you medicate and neglect the primary principles of the case and expect him to flounder alone on diet, exercise and hygiene and get well, you will meet bitter disappointment. Every case demands action and very vigorous action on your part. It is well to impress the patient that his relief depends largely upon a strict compliance with your instructions. Do not overlook the psychology of your case. My experience has been that it is first necessary to win the confidence and co-operation of the patient and willingness to help himself and your fight is largely won. He demands and has right to expect a thorough examination other than looking at his tongue and feeling his pulse; to receive an intelligent reply to his queries; sufficient time to go into the merits of his case; positive assurance (not vasilation and maybe advice); proper diet and some medicine. The average case has been the rounds and has taken plenty of patent medicines, has had a fling with the Chiro and Osteo and is pretty well discouraged and skeptical. He needs sympathy, dicision and action. Unless you can give all these your case is hopeless in your hands.

Whether to give acids, antacids, carminitives, antispasmodics, sedatives, intestinal antiseptics, cathartics or astringents depends entirely on your studies of your case. No set formula will meet all requirements,

even though all of us have pet prescriptions. If you are at a loss as to what medications to give your patient, some glib-tongued agent will extoll the virtues of dried Bulgara or Acidophylus or tell you how many cases have been cured by eating yeast cakes. Probably after dietetics and hygiene, properly regulated exercises offer the solution of many cases. Sedentary lives and inactivities of body will produce more indigestions and constipation than any other factors. It has been my custom in all cases to give the exercise factor close consideration. If they are unable to take active exercise on account of physical reasons, massage and passive movements should be advised. The inactive man at the desk all day long must not be expected to digest the food of the day laborer any more than the high society butterfly be expected to live on the rough food of her washlady. Unless we mix brains in the study and management of our cases we must not expect results. It is our duty to begin with the children in the homes and instruct parents to not only look after dietetics but to encourage the systematic play and exercise and have the bodily organs examined regularly to prevent that decay of body and mind that leads to impairment of function and disease.

While ministering to the laity, what happens to the doctor? In early practice, when the financial shoe pinches, the young doctor walks, takes his exercise, digests his food and is in perfect health. As affluences comes he rides everywhere in his automobile, walks very little, thinks he has no time for his exercise, accumulates fat, tissues become flabby and often has indigestion or gastro-intestinal disturbances. Too often returns to alcoholics or drugs to give him an imaginary "pep." The arterial system begins to show tension and the heart flags in its work and is unable to stand any unusual strain. Slight anginal pains begin to appear after eating and after exercise, and the doctor of 45 or 50 years is an old man, incapacitated from his full duties and is soon relegated to the retired list or passes on to his much deserved reward many years in advance of his allotted time. We, as professional men, do not always heed the advice we give to our patients on exercise and diet. The writer has seen too many young active medical men sacrificed on the altar of self neglect and the world deprived of their much-needed services. The rules of diet, exercise and hygiene apply to the medical man as well as to the laity and he

who transgresses against them will pay that inevitable penalty that comes, all too soon, to every one of us.

Discussion on the papers of Drs. Bell, Dickinson and Stewart follows:

DISCUSSION

Dr. Robert H. Rose, New York City, said: Doctor Bell's diet has several important and valuable features—1, it reduces the excessive use of meat which has been a dietary sin in recent years among those who are financially able to afford it, and that includes most Americans; 2, it provides a large amount of green coarse vegetables and raw foods which furnish minerals, vitamins and bulk to the diet; 3, it combats the well-nigh universal American disease of constipation; 4, it tends to prevent obesity; 5, it tends to prevent diabetes; 6, it tends to prevent high blood pressure; 7, it emphasizes in no uncertain terms, the crime of eating sugar and sweets and also concentrated starches. 100 years ago we managed to live on 9 pounds of sugar per capita per annum. This was probably too much. But what can you say when told that we now consume 30 pounds per person per annum? Cakes pies, puddings and rich foods cannot fail to undermine the health of those who eat them; 7, the outstanding principle of the dietary is that heavy carbohydrates should not be combined with heavy proteins. The explanation of this is purely scientific, though strangely enough it has not been enunciated in any of the text-books used in our Medical Schools.

Text-books do recognize that the hydrochloric acid in the stomach interferes with the digestion of carbohydrates which takes place from the action of the saliva upon them. This is more true when hyperchlorhydria is present (and it is present in most of the American people). Then it is also recognized that proteins in the stomach stimulates the flow of gastric juice, and therefore of hydrochloric acid. If the protein is taken into the stomach and at the same time a starch which requires action of the saliva upon it, the hydrochloric which is secreted to digest the protein, will interfere with the digestion of the starch. If anyone should answer that the starch is digested quickly by saliva, before the acid has an opportunity to interfere, I can say from practical experience that many patients complain of fermentation when I stop their sweets and concentrated starches the fermentation disappears. Fermentation produces oxalic forming acids. This was true in a case for whom I obtained a remarkable result by improvement of the heart action, curing extrasystolic by other method of diet, which was proof of the high degree of toxemia which existed. I cured headache and dizziness in a physician through simply stopping his sugars and reducing his bread-stuffs to a minimum.

One proof of the value of separating the concentrated starches from the meal at which heavy protein is eaten, is the way you feel when you follow the diet. You eat for your dinner, your meat, your peas, string beans, your salad and fruit, leaving out bread, potatoes, macaroni, rice and starch dessert. You eat plenty of these articles, so that you have a feeling at the end of the meal that perhaps

you have eaten a little too much. What happens? Within 15 minutes you make up your mind that you have not eaten too much. You are comfortable and taking care of the food with ease. There is no distention. Now if you had eaten bread, potatoes, and ended with a starchy dessert, so that arising from the table you felt perhaps, "I have eaten a trifle too much," then in fifteen minutes you would know that you had eaten more than a trifle too much," then in fifteen minutes you would time went on. The feeling of discomfort would then make you realize that you had eaten much too much.

I believe that Doctor Bell is right when he says that glaucoma may be due to focal infection. I have one very clear cut case to substantiate this. The patient was told by competent and well-known oculists, both in New York and other cities, that if they removed one eye they might save what little sight there was in the other. I recommended that an abscess at the root of one of his teeth be attended to. The tooth was pulled but the abscess did not stop discharging in a reasonable time. A larger incision was made and the thick wall of the abscess scraped out. For a number of years previous to this there had been constant pain in the right eye. Within three days this pain was gone never to return. It is now two years since the operation. The tension in the eye-balls was reduced to normal, and there has been some improvement in the vision, and perfect comfort as far as feeling in the eye is concerned. The patient has been on a diet according to principles here enunciated. His blood pressure has been reduced from 190 to 160 and there maintained. Doctor Bell has seen this case in consultation with me. At first my treatment so far as his eye was concerned, was only incidental, because I was dieting him for rheumatism, and the treatment which included eradication of the abscess, was a part of that treatment.

A case of ulcer of the cornea referred to me by Doctor Bell was improved at once and quickly cured through the diet. This was a woman giving to excessive eating of sweets, a case of overweight and high blood pressure. McCarrison, who was stationed by the English Government in a Province of India where the people were noted for longevity and freedom from sickness, attributed their health condition to the fact that they lived upon a diet of milk, grain, green vegetables and fruit. McCarrison says that they lived so long that in order to get rid of the elderly, they would take them to high cliffs and push them over. This diet is very much like Doctor Bell's. Experiments of McCarrison and McCollum show xerophthalmia is frequently the effect of a diet lacking in fat and soluble vitamins. There is much that is interesting in the experimental work of these men, but the time is too short for me to speak of it, though I advise you to read both the book of McCarrison and that of McCollum. They give a very good idea of developments today along that line. I will mention the fact that autopsies performed upon monkeys fed upon these faulty diets, show that the glands of internal secretion are most always atrophied when the diet is lacking—thus linking two of the most modern developments of medicine—vitamins and internal secretions.

We are not as healthful in middle life as we should be. It is all our fault. There is no reason why a large proportion of the deaths between 40 and 60 could not be prevented; and there is no reason why the period of life could not be expanded into a healthy and virile old age between 70 and 100. In a book from the library of my friend Guy Morrison Walker, printed in 1761 in England, in the list of deaths recorded there as the deaths in London, I find that about 8 per cent. are of the people above 70 years of age. I call attention to the fact that the death rate among infants has been much reduced, and this is chiefly from proper feeding; and the death rate from contagious diseases at all ages, has been greatly reduced. The great plagues have been practically eliminated and still we are not living longer, if as long, as our ancestors 150 years ago. To my mind there is only one explanation: We have not given to our diet the consideration which it rightly deserves, not even as much as we give to the feeding of our animals. As a result, we have gone far wrong, and instead of eating a health-given diet, we are eating a toxin and disease producing diet, which is cutting short our lives, reducing our efficiency, interfering with our happiness, placing many of us in the class of chronic invalids for the last half of our existence.

Dr. N. Philip Norman of New York City: It is indeed a privilege to be called upon to discuss Dr. Bell's paper. I had no idea that the other two papers would be such interesting contributions to diet and if I may offer a criticism, I might say that had Dr. Dickinson's paper been read first and then followed by the other two papers there would have been a perfect sequence of thought. Dr. Dickinson might have his paper broadcasted as a bedtime story for children and do the country a lot of good.

Drs. Bells and Stewart have given you some information that is not only applicable to the dietetics of diseased conditions but have an even greater application, namely, that of the prevention of digestive tract infections. This fact, brought out in Dr. Rose's discussion, especially concerns McCarrison's researches which have shown conclusively that gastrointestinal disease comes as the result of faulty diet. Other investigators, notably Hopkins, McCollum, Mendel, Osbourne, Hess, Greives and Shipley have shown the relation of a balanced diet to health and of a faulty diet to manifest derangements of metabolism which we recognize as deficiency diseases. I believe that most diseases are deficiency diseases, or at least their expression is encouraged by certain types of metabolic deficiencies not as yet recognizable to the extent of justifying a definite classification of the syndrome. Sir Clifford Albutt, in his masterly way, has expressed the problem very simply when he wrote "Diseases are not entities, nor recurrent phases of independent events, but are partial aspects of a universal series."

We used to treat symptoms. Some one discovered the symptom-complex and it was complexly treated. Then the focal infection craze hit the profession and in our enthusiasm many teeth, tonsils, accessory sinuses, prostates and fallopian tubes,—infection-sites accessible to examination, were removed. Some

were improved and others unimproved. Others were worse. There were few cures. Metchnikoff, Herter, Kellogg and others placed the blame on the colon. They were so much engrossed with putrefactive processes that they forgot the other foci. The end products of bacterio-proteolytic cleavage were said to have been absorbed and produced the toxemia. Lane, Draper, Saterlee, Cotton, myself and others have definitely proven that the infection of the colonic contents existed long prior to the development of a manifest intestinal toxemia. When the toxemia becomes manifest the problem is not one of putrefaction or fermentation but chiefly one of pyogenic infection of all of the sites in the digestive tract where infection is commonly found. In many instances pathological changes have occurred in the glandular and muscular elements of the digestive tract which cripples its efficient functioning and the toxemia becomes manifest after the crippled intestinal tract is no longer able to provide adequate waste removal. Lyon has added another chapter of inestimable value through his contributions of the study of duodenobiliary tract infections which in time will earn for him the merited recognition he deserves.

From this brief review one can deduce the following facts: 1st. That the majority of digestive tract infections take place because of the prolonged use of faulty food. 2nd, That focal infections of the digestive tract are interrelated and are the intermediate step between dietary abuses and manifest clinical entities. 3rd, That manifest diseases are, in the majority of instances, terminal phases of metabolic aberrations which are the result of faulty food and focal infection. Dr. Bell has been a pioneer in recognizing the clinical relation between dental, tonsillar and intestinal toxemia. Eggston and myself have shown through autopsy studies that there is an intimate relation between the involvement of infection-sites throughout the digestive tract. McCarrison's researches have shown the same thing and he has produced them with faulty diets. Dr. Bell has given you practical information regarding combinations in diet. Americans combine meat, bread and potatoes with an occasional sprig of lettuce for their daily diet. Bread and potatoes have similar dietary properties to such seed products as corn, rice, peas, beans, etc., and the extension of variety in the fare of these seed products, or by the inclusion of macaroni, spaghetti, sweet potatoes, radishes, beets, turnips, carrots, fail to improve the meal to any great extent. Yet we do combine these starchy vegetables with meat, potatoes and white bread. Such a diet will in time produce the intensest sort of upper intestinal fermentation with diarrhea, if the colonic musculature remains intact, or putrefaction, if the musculature of the colon fails in its function. This is always associated with pyogenic involvement of the commoner infection-sites of the digestive tract. We know this to be true because by collecting a specimen of the colonic contents of a freely drained colon we may demonstrate fermentative, putrefactive and pyogenic organisms in abundance. We have isolated hemolyzing and nonhemolyzing cocci

by using this method for procuring the infected material.

Dr. Bell has asked me to tell you about *B. acidophilus*. *B. acidophilus* is a native intestinal organism. It is a nontoxic germ. It belongs to the protective type of organisms. *B. coli* is a protective organism under some circumstances. In the wrong environment, *B. coli* may exhibit toxic characteristics. At least we must consider it potentially toxic. *B. acidophilus*, when fed or implanted, seems to replace first, and then reform, the intestinal flora. It re-establishes the Gram negative—Gram positive ratio which is observed in a patient in good health and feeding upon a balanced diet. It should be given in doses varying from a quart to six ounces of the milk culture daily. I believe in the milk culture, freshly prepared, and non-refrigerated. Refrigeration will preserve the milk for a long time but inactivates many of the organisms.

About colonic irrigations. I've studied this problem for years. It must be done in accordance with peristaltic cycle operative in the colon. In other words, we utilize the peristalsis to fill the colon. The tube needs not be inserted more than six inches. It is harmful to attempt to insert a colon tube more than six inches. Some colons should not be irrigated. They are the spastic colons. Actual harm results from promiscuously irrigating spastic colons. For this reason alone, nurses and technicians should be disqualified as irrigators. We do not use antiseptic solutions. We simply re-educate the colon to physiologically function by stimulating the normal peristaltic cycle. By hydrostatic distention adhesions, kinks, angulations, etc., can be non-surgically corrected. Cathartics are discontinued and the patient is taught to forget about his bowels and think more of the kind of food he is to nourish himself with than with how he is to get rid of the starch and meat paste with which he usually fills his stomach.

Dr. William B. Olmstead, Trenton: As other speakers have already discussed Dr. Bell's paper and also Dr. Stewart's, I will only say a word to express to Dr. Bell our appreciation of the splendid paper he has presented. The question of diet is one of the most important before the profession and the public. Some day people will eat sensibly and thereby contract fewer diseases and live longer. We all subscribe to the theory of focal infections, and that includes the putrefactive changes in the intestines due to improper feeding. I know that the relation between bad teeth, infected tonsils and auto-intoxications and eye diseases is constant and sure. In closing I would say that I am sorry Dr. Bell has taken a more liberal view on the question of starches and sugars in the diet, and I still believe that white bread, potatoes and sugar are bad for any one, whether in combination or not, who eat them. Thank you very much.

Dr. Tom Williams, Washington, D. C.: I had expected that Dr. Dickinson's paper would go into a great deal of visceral neurology, and I was prepared to listen to do with great interest; but it was an allegory, and not being very much versed in dealing with allegorical formulations, I have made a few notes about

other matters which I would rather speak about perhaps, if you will pardon some generalization about this discussion. In the first place, may I make an excuse that although I am a neurologist, I was first a general practitioner, and I have always been very much inclined to study and apply dietetics; so much that some ten years ago one of my neurological colleagues in Washington, on the presentation of a case with an organic lesion to our Neurological Society, turned scoffingly to me and said, "You don't think you can cure that case with diet, do you?" It has been said that desperate cases require desperate remedies, but, as Dr. Stewart very wisely said, the desperate case is quite exceptional and as a very general rule one can afford to watch and wait, and one will only be wrong very rarely; and watching and waiting includes dietetics. I do not think, like Dr. Stewart and like Dr. Gant, who will speak tomorrow, that we are falling into a tendency of adopting a routine run made in examining patients. Nobody believes more than myself in thoroughly examining patients, but not every patient needs to be examined for everything. I believe more harm on the whole may be done by that, financially to the patient and emotionally to the patient, than the total good one does by never missing an obscure case, because of course the man who does not examine every patient for everything will occasionally miss a diagnosis. At the same time, I have had some experience with group medicine cases that have come to me afterwards, where everything has been examined and where the diagnosis has been completely missed from lack of proper co-ordination of the findings.

Now as to Dr. Dickinson, he was very hard on the poor brain, I thought. One of the most eminent of Americans who made a great mark in Europe, was the painter Whistler, and when he used to be asked with what he mixed his colors, he used to answer, "I mix them with brains." And so I think with diet we have to mix our diets with brains, and we cannot leave the stomach either to itself or to be guided by the kind of palates that we have taught vitiated tastes. I do not think that the natural palate won't go wrong. Some of my Western friends who go hunting a lot tell me that they can always turn the mules loose in the feed-trough and they will never overeat, but horses will eat themselves to death if they give them a chance. The horse is a sophisticated individual like ourselves and the mule is a creature of nature, I suppose. We are in a laboratory age, so I would like to illustrate by an experiment, what mixing with brains did; namely, my own brains on my own stomach at lunch today—and here I stand in spite of Dr. Bell; having had a very light breakfast, I was very hungry and I ordered a lunch as follows: Clams, clam chowder, beef, carrots, string beans, potatoes and French rice-cake; lettuce undressed. I was glad to see no vinegar because I felt that Dr. Bell would not then disapprove of me quite so much. Then I had junket, which I found to be not what we call junket in Washington; namely, milk potted with rennet, but what the French call cream and we call custard. Junket—I didn't eat it, of course, (laughter) not wanting to combine an egg dish, having already eaten as much beef as I could. Then I

had ice cream, stewed strawberries, water-melon, whole wheat bread, and tea, which I did not drink because it was too strong—and here I stand, in spite of Dr. Bell. But I shan't eat that tonight again, I shan't do it again. One sin a day is enough for absolution. In that connection I think that perhaps we are not giving our children a fair chance. Why does a child and a young woman, who is also very often only a child, especially the debutante that Dr. Stewart talks about (of whom I see a great many in Washington), have such vitiated tastes for sugar? I think it is perhaps because sugar is easy to her hand and every temptation of the confectioner and drug store is thrown at her—the man who gives the box of candy. She cannot avoid temptation, even if she did say the Lord's Prayer, "Lead us not into temptation;" she cannot avoid being led because sugar is everywhere, and she is not tempted in the same way by that which nature calls for; namely, the sweet fruits, and she mistakes the desire for that which contains the basis of salines and vitamins along with sugar and other elements, the sweet fruit, and takes for that the artificially prepared sugar of commerce; and the more you eat of sugar, the more you want of it, because it hasn't got what you do want; you still crave for the vitamin and the saline, and you go on eating the sugar.

I think if we give to our young women who over-eat sugar and become obese, a sufficiency of the kind of food they really crave, they won't have to be forbidden sugar because they will like the other foods much better. We don't consider enough, perhaps, in connection with the stomach, the body of chemistry. I expected Dr. Dickinson to say more about the control of the stomach by the nervous system and by the hormones, and the control of the lower intestine through the hormones and the nervous system. It is all so beautifully co-ordinated as a whole, because after all the stomach is merely a dilatation on the digestive tube, and so is the liver merely an offshoot from the digestive tube, but of course I can't say anything about it because he didn't and because it would take me too long. I do want to say one thing, however, and that is about the difference of opinion in what we have heard today, and I want to give another difference of opinion, to make it still more confusing. Some twelve years ago I published a dietary, a dietary with special reference to cases of arteriosclerosis of the brain or of hypertension with arteriosclerotic or pre-arteriosclerotic symptoms. That diet was used with great benefit to many patients. The principal of that diet was a very strict limitation of proteins and the giving of a large protein meal at midday, and the giving of exercise some time subsequent to that mid-day meal, and a light meal at night, composed chiefly of carbohydrates. A diet of starch is very uninteresting, and no one will eat too much if he can get other things. So I felt from that experience that it was safe to allow patients to let their appetites guide them in eating starches. Of course, that is subject to exceptions, as I grant.

We are told by many writers like Hare and Smith in Jacksonville, and Dr. Bell today and the doctor who followed him, that the criminal thing is not the proteins but the carbohy-

drates, in cases of high blood pressure. How are we going to reconcile those discrepancies? We are told by other clinicians that it is the total intake which is the important matter in such cases. I am inclined to believe that there is a good deal in that: That we have to limit the total intake; not only the starches, but the protein also. Recognizing, as I do, the fact that there are certain cases of fermentative types where a complete suppression of all carbohydrate food for a period is beneficial, I do not at the same time believe that it is safe to deal with a human being, and especially one over forty, by prescribing a dietary for a long period of time, composed mainly of proteins. That, I think, is only a temporary expedient. I believe we will eventually produce in that patient acidosis with all that follows—nephritis, hypertension, etc. I should like to have said a few words about the psychological factors, but I will just say one word. Dr. Dickinson spoke of laughter. It is a very old story and we often forget it. I think in the Bible there is a proverb which says something to this effect: "Better is a dinner on herbs with contentment and cheer, than a feast in the seat of the mighty."

Dr. Henry B. Costill, Trenton: I thought you gave my time to Dr. Williams. I cannot pass the very unique paper of Dr. Dickinson's without a few words of comment. I think the committee is to be congratulated on the arrangement of this part of the program. Had Dr. Bell's paper had come before Dr. Dickinson's and the latter's stomach had had the benefit of that dietary list there never would have been any paper for Dr. Dickinson to present. I think Dr. Williams struck the keynote in reference to this method of dietaries. As we listened to these various papers on diets. Dr. Johnson said he wanted to go home; that he could not stand all this stuff about diets. Then when he told about these natives who had to live on this diet in order not to go over the precipice, Dr. Johnson broke down and said, "I'd a good deal rather go over the precipice than go on the diet." To us old fellows who have lived through these things and eaten pretty nearly what we pleased, and apparently have gotten along alright, without having much high blood pressure and without becoming very obese, it seems that the common sense that Dr. Williams injected into this thing is quite to the point and it meets with our approval; namely, that it is the total intake that is particularly dangerous and taking so much all at once. (I notice that some of us have not gotten as obese as some of these fellows who have lived on a diet.) I believe that the American we have developed is one of the principal causes for this: A man eats very little breakfast and very little lunch, and when night-time comes, he is hungry, just the same as Dr. Williams was; he gets down to a pretty good hotel and sees a long menu before him, containing pretty nearly everything, and he goes the limit, the same as Dr. Williams did; and it is that gorging, I think, that does more harm than the individual things that you possibly cut out.

Dr. Bell, closing the discussion: First of all I wish to express thanks for the invitation to read my paper before your distinguished Society. It is a great honor. I thank the doc-

tors also for their generous discussion, especially Drs. Rose and Norman who are studying on the diseases of the digestive tract nearly all the time. With regard to what Dr. Williams ate for lunch, I merely say: Of course Dr. Williams is on a spree now and we won't hold that against him, but I am quite sure Dr. Williams, from looking at him, does not eat that when he is at home. In regard to the well-balanced diet, I think you will notice, if you study this diet sheet of mine, that there is plenty on there for everybody to eat. I think we all eat too much; we have that evidence. There were 93,000 cases of cancer last year, 10,000 more than the year before, here in the United States. I had a doctor friend in the early fifties, who died with cancer just this week. I had another friend who died this summer, and he was in the forties. He died with pneumonia in just two days. There must be something wrong with civilization, with our methods of living, if people are dying like that. Bad teeth and diseased tonsils, and the food, to my mind, are the greatest factors in this condition. McCarrison is the greatest food expert in England today. He lived in the Himalayas for seven years with these people, and the entire time he was living there he never saw a case of dyspepsia, duodenal ulcer, appendicitis, or cancer. He says that himself. And those people's diet was almost the same as this one of mine; it is plain and simple and raw foods, raw milk and fresh vegetables. So I think this diet is well worth considering and I think it is certainly one of the sure roads to longevity.

Dr. Dickinson, closing: We are getting to the humorous stage. The dietitians always make me laugh. They talk about the kind of food you should eat and the kind you should not eat, but they say nothing about how it shall be cooked, and that is a very important matter. I think that our friend here is right: It isn't so much what you eat as how you eat it. Dr. Bell spoke about cancer. In those countries where meat is not obtainable and they live entirely on the carbohydrates, cancer, epilepsies, and asthmas are largely absent. The effect of diet on the individual varies with the individual; it is a case of energy more than anything else, it seems to me. As to my little paper, if I had prolonged it for everything that was spoken of, it would have been too long. Those papers should always be short or they will be spoiled. I did mention the internal secretions in a way. That is one thing we forget. The energy of the stomach depends upon the activity of the endocrins. If they are in order, the stomach is in order. I have seen more than one case of a tired stomach helped by small doses of thyroid and pituitary. The man with a tired stomach, who overworks, who does not feel like eating, whose food sours easily, can be toned up in ten or fifteen minutes by a small tablet of your thyroids. Don't forget that your internal secretions are important. A nap, toning up your nervous system, is important. But the most important thing of all is, be your own boss.

Dr. Stewart, closing: Mr. President, I only want to express my appreciation for the remarks that have been made and for the pleas-

ure of hearing Dr. Bell's paper. If I might stress any one point at all in connection with the gastro-intestinal diseases, it would be to re-emphasize the point that I brought out in my paper; namely, that the best treatment of gastro-intestinal disease is the preventive one, and if we expect to have a future citizenship of young men with disordered stomachs and with disordered conditions of digestion and poor teeth, it is going to be a very sad reflection on the knowledge of the doctor of today if he does not begin with the child in the home and preach, day in and day out, to the mothers and to the fathers, and to the doctors who are associated with him in the professional work; that they shall look out for the little folks and see to it that they will come on and live to the age of our good friend Johnson—and going some then!

A METHOD OF PREVENTING THE REMOVAL OF TONSILS AND ADENOIDS AND ITS USEFULNESS IN THE TREATMENT OF NOSE AND THROAT DEFECTS

By **Arthur E. Ewens, B.S., M.D.,**
Atlantic City, N. J.

For many years the writer has shared the sentiment of that group of the profession which does not altogether endorse some of the surgical procedures commonly employed in nose and throat practice,—notably the removal of adenoid tissue from the oro and naso pharynx and destructive operations within the nasal cavities. That these procedures are frequently attended by negligible results is well known, and it is not unusual to witness effects which seem to come within the category of positive harm. It is not prejudice, however, that is even partly responsible for the presentation of this paper, although it is hoped that the observations herein reported, when verified by the profession at large, will constitute an effective plea for greater conservation in the treatment of diseases of the nose and throat.

Whatever may be the line of reasoning that justifies the present-day wholesale removal of tonsils and adenoids, one very important element in its consideration is apparently almost ignored, i. e.—the probable function of the structures so readily sacrificed. A very natural response to this criticism would be that the physiology of the tonsils has never been definitely agreed upon, and that, even if their exact function was known, it would have little or no weight in the presence of a pathological condition demanding

surgical removal. To uphold their contention my opponents might cite the approved treatment of a diseased appendix, and yet this, in reality, is not a parallel at all; because there is so far more room for conjecture as to some important function of the tonsils and, on the other hand, less evidence of a comparable danger from diseased tonsils that remain undisturbed. It has always seemed to me that tonsils, because of their histology, their known relationship with the cervical glands, and the obvious need for an abundance of lymphatic protection in the exposed avenue that serves both respiration and deglutition, should be regarded unquestionably as important units of the general lymphatic system. If this be true, it would seem to place the promiscuous excision of lymphoid tissue from the throat upon an extremely unscientific footing.

Experience of recent years has convinced me not only of a vital need for the lymphoid structures with which the upper respiratory tract is so generously provided, but that it is in the splendid performance of their important task that they become surcharged with the products of bacerial activity and themselves ultimately infected. Hence the logical question seeming to confront us is how to lessen the burden put upon these barriers to infection, and not how to get rid of the barriers themselves simply because they have suffered (perhaps only temporarily) through the exercise of their protective function. Most certainly we would not direct local treatment, surgical or otherwise, to an axillary or inguinal adenitis without first attempting to determine its probable origin in some extraneous focus of infection. Why, then, should we not, by analogy be induced to reason in a similar manner when confronted with the involvement of glandular structures in the throat? It is true, of course, that glands communicating with, and directly exposed to, a mucous surface would be much more susceptible to primary infection than glandular structures not so situated. However, one of the purposes of this paper is to show that a large majority of infections occurring in tonsils are probably not distinctly primary, but find their way into the tonsillar substance and peritonsillar tissue presumably through lymph-channels,—the infectious material being conveyed from a broad expanse of catarrhal

mucous membrane, and not necessarily from that portion immediately covering the gland.

A series of approximately two thousand cases has revealed to the writer the rather startling fact that a large share of blame for protracted naso-pharyngeal catarrh, tonsillitis, chronic hypertrophy and its various obstructive manifestations in both the throat and nose can be squarely placed upon that apparently innocuous appendage,—the uvula. At first sight this claim may seem to border upon absurdity, but it gives promise of becoming an accepted clinical fact.

Circumstances antedating the investigation that warrants the foregoing statement were quite accidental. Their recital should not be omitted inasmuch as they contributed the very foundation and incentive for all that is embodied in this report. As far back as 1905 I became enthusiastic over the excellent results obtainable from uvulotomy as a measure for the relief of aggravated and protracted coughs, especially that type commonly known as the "cigarette cough." Its earlier employment was restricted to those cases in which the uvula was extremely elongated, but it subsequently proved equally efficacious in many instances where elongation was not so pronounced. The number of cases so treated, many of them amongst the transient population of Atlantic City, grew in the course of years to a rather substantial total. From time to time there were renewals or acquaintance with some of these out-of-town patients, and occasionally there would be one who would show a disposition to exaggerate the benefits experienced during the years following amputation of the uvula. Statements of this character did not engage any serious attention, however, until about five years ago. The ensuing investigation had not progressed very far when it became apparent that these supposed "exaggerations" possessed a real semblance of truth and value.

As this investigation advanced the field of application for "uvulectomy" steadily broadened until, in my hands at least, it has attained a scope amazingly inconsistent with its lack of support in medical literature. ((The term "uvulectomy", in preference to uvulotomy, is used advisedly, removal of the uvula in its entirety being the procedure advocated.)

As the skepticism in store for this initial publication of results from "complete uvulectomy" can hardly be lessened by presenting detailed case-reports, only a summarized account of its effects and usefulness will be attempted, as follows:

1. It never fails to effect prompt improvement of catharrhal conditions in the throat and nose to a degree that is plainly discernible, and there are few coughs of any description that do not yield, in some measure at least, to complete uvulectomy.

2. Susceptibility to common "colds," acute pharyngeal and laryngeal inflammations, tonsillitis and quinsy, so pronounced in many individuals, is decidedly lessened.

3. Chronic hypertrophy of the faucial tonsils, and other susceptible lymphoid structures of the pharynx, is materially reduced in many cases, especially during early childhood, and always to a degree that would compel hesitancy in restoring to popular surgical measures. In conjunction with this observation it has been the writer's pleasure to repeatedly witness relief from tinnitus aurium, as well as marked improvement of hearing when the impairment was ascribable solely to obstruction of the Eustachian orifices.

4. Nasal obstruction, due to encroachment of the turbinates, whether associated with marked deformity of the septum or not, is usually relieved to a degree that surpasses the benefits that ordinarily accrue from operations within the nasal cavities. Coincident with this effect there is often relief from associated sinus symptoms.

5. Mention should be made of the cases (somewhat too numerous to be regarded as mere coincidences) in which subacute arthritis, postinfluenzal neuritis, and myositis, that had resisted previous treatment, showed improvement or completely disappeared.

6. A response has been observed in a few cases of bronchial asthma and hay fever, but results on the whole have been rather disappointing. The effect in certain cases of so-called "cardiac asthma" has been most gratifying. Where coughing has been a conspicuous symptom, although presumably of cardiac origin, it has yielded sufficiently to relieve the over-taxed heart and bring about a decided abatement in the dyspnoea.

7. Correction of that nocturnal nuisance,—“snoring,” can usually be effected.

8. Anaemia of obscure origin, and re-

bellious to treatment, when associated with pronounced pharyngeal catarrh and tonsillar involvement, often responds. This observation has been remarkably constant in children.

9. In only a limited number of cases of pulmonary tuberculosis has the consent of the patient to a proposed uvulectomy been gained, but in every instance where cough was a troublesome symptom results have more than justified the measure employed. This phase of the subject is intensely interesting because of the marked general improvement in these patients consequent upon the abatement of aggravated coughing. The extreme frequency with which this type of tubercular patients present an angry, elongated uvula, and the fact that the history of a cough in these cases so often widely antedates all of the other classical evidences of the disease, opens a wide field for conjecture and investigation. In the light of future disclosures it is my opinion that an "abnormal uvula" will be assigned a conspicuous place among the aggravating, if not the predisposing, causes of pulmonary tuberculosis.

The apparent extravagance of the foregoing statements may seem inconsistent with the promulgation of a new subject, and will naturally give rise to the question that has already been asked, viz.—"Does the originator admit that such a thing as a 'normal' uvula exists?" In answer to this I can only say that the uvula's demonstrated potency for harm precludes an admission that any catarrhal throat can contain a normal uvula, whether appearances clearly denote abnormality or not. My own experience impels me to prophesy that the removal of uvulae from the throats of children will some day become a common practice, —perhaps a routine comparable to vaccination. The most skeptical will be speedily converted after a practical demonstration of its effects upon the characteristic condition in early childhood that nowadays demands the removal of tonsils and adenoids.

It is probable that pathological investigation along the lines suggested by this paper will disclose definite reasons for the clinical observations reported. However, until this more exact explanation has been revealed, it shall be my opinion that the uvula gives rise to disturbances in the throat and nose for the following reasons:

In the first place the uvula is obviously a source of mechanical irritation when elongated to an extent that permits it to drag upon the tongue, or upon the posterior pharyngeal wall when the individual is recumbent, and particularly so when repeatedly subjected to the harsh treatment it receives in the act of snoring.

If its vascularity is an index to its vitality and resistance to infection, it possesses very little, because in the removal of over two thousand the control of hemorrhage has not become necessary in a single instance, and it is exceptional to witness a persistence of oozing for as much as five minutes. Many uvulectomies are accompanied by the loss of practically no blood at all.

Its anatomical location and conformation keep it supplied every minute with from sixteen to twenty-four fresh installments of foreign material, bacterial and otherwise, with which the atmosphere of a humid climate abounds. Presenting, as it does, a moist, warm, pendulous surface, feebly supplied with blood in contrast with adjacent structures, it provides an ideal bacterial nidus.

A macroscopic examination after removal shows it to be composed mainly of reduplicated, bloodless mucous membrane exhibiting marked signs of thickening, and enclosing but little muscle tissue, the latter being found chiefly at its extreme upper portion. Its gross appearance would enable no one to regard it as a healthy piece of tissue in any instance where removal has been deemed expedient.

After giving due consideration to these points, it should not greatly tax the imagination to form some understanding of the potentiality for harm residing in this tiny and superfluous bit of tissue. The bacteria that it incubates spread by direct continuity to adjacent structures, and remote effects are produced through the medium of lymphatic and venous absorption from a broad surface thus involved. The nasal cavities, pharyngeal vault, faucial and lingual tonsils and the larynx are none of them very distantly removed from this nidus of infection.

In the minds of most people, including the medical profession, there seems to be an inherent idea that an indispensable utility resides in the uvula. Despite the obviousness of its real function, it does not serve any vital necessity. This has

been clearly established by a wide experience, and as testimony to the writer's conviction in this matter it might be stated that he removed his own uvula quite some time ago.

Disappointment is apt to follow an attempt to determine in any given case "how much" of the uvula should be removed. No procedure is recommended that does not contemplate removal in toto.

In the series of cases subjected to this method of treatment the extremes of age have been "sixteen months" and "eighty-three years." In children under six years general anaesthesia is usually required, but the operation can be made practically painless by the topical application of cocaine.

In the writer's practice "uvulectomy" is done as follows: After removing mucous from the surface of the uvula and surrounding parts by spraying with some suitable detergent, a four per cent. aqueous solution of cocaine hydrochloride, in cautious amounts, is repeatedly applied, first to the uvula anteriorly and posteriorly, then to the soft palate immediately above and the margins of the posterior pillars of the fauces. Firm pressure of the swab into the angles of junction between the posterior pillars and the uvula has been found to facilitate anaesthesia, which is usually complete in from five to eight minutes. During this preliminary the patient is permitted to gain some experience in manipulating the tongue-depressor, this anticipation having proven distinctly advantageous. With the tongue held out of the way by the patient, the uvula is grasped with a pair of Noyes' alligator-jaw forceps near the level of its junction with the posterior pillars, and moderate traction made downward and slightly toward the operator. Severance is then effected with curved tonsil-scissors (points down) at a level that promises to leave an uninterrupted arch to the resulting margin of the soft palate. Retraction of the mucous membrane usually leaves, however, a slight protrusion of muscular tissue beyond the palatal arch. After the patient has had a few swallows of cold water this piece of tissue is drawn down and excised, and any other observed unevenness is similarly corrected.

After treatment involves no difficulties, and few patients experience any apparent need of it after the third or fourth day.

Healing is usually complete within two weeks. Immediately after operation it is advisable to caution the patient against the added discomfort occasioned by food or drink that is hot, highly seasoned, acid or extremely sweet. The routine practice has been to prescribe "mentholated throat tablets with cocaine," to be dissolved on the tongue almost continuously for the first twenty-four or forty-eight hours. After that a gargle that is diluted with water, equal parts, and used every hour or two, is ordered, as follows: Phenol, 10 minims; glycerine, half ounce; Alkalol, an ounce and a half; Dobell's solution, sufficient to make eight ounces.

County Medical Societies' Reports

BERGEN COUNTY.

Fred S. Hallett, M.D., Reporter.

The Bergen County Medical Society met on December 11, 1923, at the Hackensack Hospital. Dr. G. L. Edwards, president, occupied the chair. About fifty members were present.

Dr. Charles Vroom of Ridgewood, New Jersey, read the scientific paper of the evening. The paper dealt with Insulin in the treatment of diabetes mellitus, covering the dietetic treatment of the disease as well, and emphasizing the importance of balanced diets after a thorough study of the patient's metabolism and chemistry of the blood. He pointed out that patients who can assimilate eighty to a hundred grams of carbohydrate in twenty-four hours without a hyperglycemia or glycosuria, can well do without Insulin. He also brought out the dangers of hypoglycemia produced by an overdose of Insulin. He demonstrated the latter on a rabbit and brought the animal back to normal by a subcutaneous injection of five per cent. glucose solution.

Dr. Vroom's paper was followed by a practical demonstration and review of food values by Miss D. Armstrong, the hospital dietitian. Miss Armstrong exhibited assorted diets of known caloric values, also giving valuable information on how to instruct diabetics at home to prepare their own balanced meals.

Dr. Morrisson, representing the State Medical Society, asked the meeting for their stand on the new Venereal Bill which is pending in the Legislature. The doctor was given a unanimous vote of support. He also told the members of the new clauses in the group insurance policies.

Discussions followed with all the members participating. After a social session the meeting adjourned.

CAMDEN COUNTY

F. William Shafer, M.D., Reporter

The last regular meeting of the Camden County Medical Society for this year was held at the Camden City Dispensary on Tuesday, December 11th, at 3 P. M. President, Dr. J. E. Howard presided.

Dr. A. H. Lippincott reported the transactions of the State Welfare Committee, and his

recommendations concerning the control of venereal diseases, and the Marriage Bill, as suggested by the State Committee, were unanimously adopted.

Drs. Jos. E. Nowery and Chas. E. McWilliams of Blackwood were elected to membership.

Dr. E. W. Kaufman was admitted to membership by transfer from Salem, N. J. The following applications for membership were received: Dr. Jos. C. Lovett, Director of the Camden City Municipal Hospital; Dr. Lavinia Clement of Haddonfield; Dr. Cedric E. Filkins of Oaklyn and Dr. Gordon West of Camden.

A letter from Dr. Hill of the American Society for the Control of Cancer was read.

The following program was followed: "Intestinal Obstruction from the Standpoint of M.D., Trenton, N. J. Discussion opened by Paul M. McCray, M.D. "Insulin," by Thomas C. Lewis, M.D. Discussion by Arthur J. Caselman, M.D., and Thomas M. Kain, M.D.

The General Surgeon," George N. J. Sommer, Dinner was served at 5 o'clock. There were 60 members present.

HUDSON COUNTY

Wm. Freille, M.D., F.A.C.S., Reporter

The Hudson County Medical Society met on December 4th, 1923, at the City Hospital, Jersey City.

Dr. F. J. Quigley, chairman of the Legislative Committee, spoke on the Harrison Licensing Bill, to be introduced at this session of the legislature, if it met with the approval of the various county societies. When this bill was presented last year, it required the physical examination of both applicants prior to marriage. It seemed to receive most of its opposition from those who disapproved of the examination of the female, and therefore the bill has been modified to call for examination of the male only. The speaker then read in full a draft of the act, showing its various provisions, penalties, etc.. He asked for discussion and definite action, inasmuch as the Welfare Committee would expect him to report on the following Sunday.

Dr. Rosenstein spoke of the advantages and disadvantages of the proposed legislation. Dr. M. A. Swiney of Bayonne, thought well of the bill, but feared it would be like the Volstead Act, that a few physicians might make a specialty of giving certificates without examination. He called attention to the necessity for making a Wassermann and perhaps other tests, running up to \$20 or \$30, and could foresee that certificates might be given for \$10. Dr. Knox of Bayonne, said the bill would work both ways. A man did not need to get married if he had venereal diseases; but they often became neurasthenic from fear that the disease may have been acquired. So the reporting of venereal diseases, while it apparently had done some good, has also done harm. If a doctor gets credited as reporting this case to the State, a prospective patient will seek help from a drug store or elsewhere.

Dr. Donald Miner referred to syphilis as an almost universal disease, quoting statistics to that effect. While he realized that this provision was a step toward limiting it, he felt that the topic was important enough not to be decided on hastily, and was inclined to have

the matter fully studied, discussed and reported on later. Dr. Quigley told the society that this affair had been before the profession for three years; and Dr. Joseph Koppel emphasized this fact and the impossibility of getting the bill passed in its original form. He stressed the ravages made by venereal diseases, particularly among women and children, and advocated immediate action. In this he was followed by Drs. Jos. Schapiro, Jaffin, Rittenauer, Urevitz, Kelly, Yeaton.

In answer to Dr. Knox, Dr. Quigley stated that Wisconsin had such a law, which the Supreme Court of the State declared to be constitutional. After further discussion from many angles, it was moved and carried that Dr. Quigley be instructed to inform the Welfare Committee that the consensus of opinion of the Hudson County Medical Society was for the passage of this bill as it stands, or whatever changes they may deem fit to make.

Dr. M. A. Swiney of Bayonne, referred to the extensive accounts (even of minor operations) which recently appeared in the local press, in connection with the series of clinics recently held (principally by New York men) at the City Hospital, and which he felt was nothing short of advertising, or at least they must have had interested press agents. Dr. John Nevin, Medical Director, said that the press seemed to consider the clinics of sufficient importance to be covered by the papers, and though it might seem strange, he had no further answer to make to Dr. Swiney. Dr. Kelly felt that there were corporate bodies of physicians in New York who were actually advertising, although within the law.

Dr. A. Nelson was in sympathy with Dr. Swiney. He cited the instance of a prominent New York specialist (who had read a paper before the society,) to whom he referred a patient, who had practically nothing wrong with him, but who nevertheless received follow-up letters, asking after his welfare, etc.; to cap the climax, the last letter informed the patient that the specialist had recently published a book, to which he asked him to call his doctor's attention.

Nine applications for membership were approved, and seven referred to the censors.

The special business before the meeting, was the report of the committee appointed last Spring on the Faison Memorial and Academy of Medicine. Dr. S. A. Cosgrove reported in detail. Dr. Kelly, the president, asked for a free discussion, and Dr. Margaret Sullivan opened it, advocating some common meeting place; a medical home. She was followed by Dr. Frank McLaughlin, who talked on the necessity of a fund for erecting the proposed building, and a fund for maintenance.

Dr. Cosgrove asked that the recommendation of the committee be taken up serially discussed and settled, but before this was done, he presented Dr. J. B. Morrison of Newark, N. J., Secretary of the State Society, whom he thought could enlighten the members on this subject:—

Dr. Morrison then told at length the methods used in establishing and maintaining the Academy of Medicine of Northern New Jersey, going into the practical details of dues, income, taxes, etc., and illustrated the progress made in ten years. With the material

in the Hudson County Medical Society he saw no reason why they could not easily accomplish their object. He answered several questions, and his lucid and practical talk was thoroughly appreciated, and the Society tendered him a vote of thanks.

A motion to increase the dues was discussed by Drs. Kelly, Swiney, Woodruff, Cosgrove, Nelson, Sprague, Londrigan, Jaffin, Pagalia and Behrens. Others talked on the various points as recommended by the committee.

Dr. C. M. Peters, D.D.S., asked for a committee to meet with the Dental Society, as he knew they would be interested in the Academy. This brought the suggestion that druggists and nurses might also be included.

The president, Dr. C. B. Kelly then passed around subscription pledges; \$16,000 was totalled as a nucleus for the project.

MIDDLESEX COUNTY

F. C. Johnson, M.D., Secretary

The 107th annual meeting of the Middlesex County Medical Society was held December 19, 1923 at the Hotel Klein, New Brunswick. It was one of the largest and best meetings the society has ever held. It was called to order by the President Dr. Charles W. Naulty at 4.30 P. M.

The ordinary business was transacted and the election of officers was held. The Nominating Committee submitted the following list:

President, Dr. A. L. Smith, New Brunswick; Vice-President, Dr. J. F. Webber, South Amboy; Secretary, Dr. F. C. Johnson, New Brunswick; Treasurer, Dr. D. C. English, New Brunswick; Delegates to the State Society, Drs. A. L. Ellis, Metuchen; W. F. McCormick, Perth Amboy; R. L. McKiernan, New Brunswick. Alternates, Drs. B. M. Howley, New Brunswick; J. V. Smith, Perth Amboy; S. E. Selorer, South River.

These were unanimously elected.

Dr. David C. English read a most cordial letter to the society from his esteemed friend, Dr. Howard A. Kelly of Baltimore stating his sincere regret in being unable to attend this meeting.

The necessity and desirability of having more frequent and more thorough autopsies performed in cases of violent and sudden death and other circumstances brought forth lively discussion about the office of County Physician, and the president was authorized to appoint a committee of three to confer with the Board of Freeholders and the County Prosecutor in reference to the matter.

The leading paper of the evening was read by Dr. Edgar D. Oppenheimer of Mount Sinai Hospital of New York City on "Polyarticular Arthritis;" an able discussion of the Etiology, Pathology, Symptoms and Treatment of this distressing disease.

Dr. Wells P. Eagleton appeared before the Society and outlined the work of the Welfare Committee of the State Society and enlisted the spot of the hearty co-operation of all members of the society.

Dr. Andrew F. McBride, our new Commissioner of Labor outlined the scope and field of activity of the department which he has so generously undertaken to direct. The support of the society as of every medical man

in the State will surely be his throughout his term of office.

Dinner was served with fifty-seven members of the society present. Entertainment after the dinner was the unique performance of a remarkably trained little horse "Black Bear," exhibited by his master, an old horse man with an abundance of horse-sense himself.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

The regular quarterly meeting of the Morris County Medical Society was held Tuesday afternoon, December 11th, at the Physiatric Institute in Morristown, through the courtesy of Dr. Frederick M. Allen, Director of the Institute and a member of the Society.

President Dr. George R. Hampton presided over a large attendance of members and invited guests; among the latter being Dr. Well P. Eagleton, President of the State Society and Drs. Bradford Murphy and J. Harley Stamp recent additions to the medical staff of the State Hospital at Morris Plains.

The roster of membership of the Society was increased by the election of Dr. George B. Emory of Morristown, Dr. O. M. Delaney of Dover and Dr. M. Kemper Willoughby of Morris Plains.

The following memorial to deceased member Dr. Emma C. Clark was unanimously adopted and ordered spread upon the minutes and sent to the bereaved members of the family of the deceased and to the Journal for publication:

MORRIS COUNTY MEDICAL SOCIETY IN MEMORIAM

Death, the great and unsparing reaper, recently entered our Society and took from us our respected colleague,

DR. EMMA C. CLARK

Dr. Clark had a most retiring and self-effacing disposition; so much so that her intimate association with many of our membership was limited. But with those who knew her best her sterling worth impressed itself upon them.

Dr. Clark was a woman of the highest type; therefore, as a physician she was true to her chosen profession. Her ideals were high, so high that she failed to reach them. Her last words spoken at a medical meeting in our little hospital at Dover were: "I tried so hard. I had planned so much; my strength failed me." She was speaking of her work in the laboratory, of how she had hoped to enlarge and better it.

We shall long miss Dr. Clark and think of her as one of the Creator's choice handiworks.

We would extend our sincere sympathies to her aged mother who is so sorely afflicted and to the three remaining sisters who mourn her loss.

Dr. Clark looked death in the face with calmness, preparing quietly for it as though for a vacation and rest. *She Is Resting.*

Routine business being disposed of, the presiding officer introduced Dr. Eagleton of the State Society, who immediately launched into an address of much particularity and graphic description, expounding many subjects bearing upon the welfare of the profession in

general and of intimate interest to the county society. In the masterful manner, Dr. Eagleton expensed much "food for thought." The work and accomplishments and future aims of the State Welfare Committee were delved into deeply and Dr. Eagleton paid a high tribute to the activities and energy so loyally expended by Drs. William F. Costello and Julia C. Mutchler of our society who are members of the State Welfare Committee. He outlined the legislative program, carefully reading and explaining in detail the Venereal Disease Control bill and answering many questions concerning it. The entire program as outlined by Dr. Eagleton was unanimously indorsed by the society.

Speaking of the rift of yesteryears that seemed to exist between State institutions and the profession in general, Dr. Eagleton commended the attitude of the management at the State Hospital at Morris Plains in so cordially offering to co-operate with the medical men by making available to them the laboratories, clinics and other facilities and said that he had written to Superintendent Dr. Curry of the State Hospital expressing his appreciation.

The gratefulness of the members was unreservedly made manifest to Dr. Eagleton for his stirring address and wise counsel.

The medical topic of the day was "Treatment of Diabetes with Diet and Insulin," by Dr. Frederick M. Allen, director of the Physiatric Institute. Dr. Allen pointed to the ocular evidence of results accomplished, in that while at a previous meeting of the society at the Institute there were to be seen plenty of half-starved, emaciated diabetics, now one could look around and find no starved, invalid diabetics in the house; the great blessing of insulin is that we can take diabetics almost in the grave and make normal useful people of them; that is the miracle. The reverse side of the picture is that insulin must be given accurately and with proper diet; we seek to avoid insulin if we can; in the milder cases we get along without it and in extreme cases use it. With the combination we have good results and have had no bad results and not one that would not respond. It is the control of the diabetes that works the miracle.

Dr. Allen presented patients and passed around photographs taken in their emaciated state and others showing them in normal flesh; the cases presented ranged from a child who developed diabetes at two and a half years of age who put on weight rapidly under treatment, after a marked loss of weight, to an adult physician who developed diabetes while a student at Harvard on whom the insulin treatment was started seven years after the diabetes commenced, with the result that instead of being an invalid the physician will within a couple of days go out to practice medicine.

A very interesting paper on "The Complications Which Occur When Blood Sugar Is Not Properly Controlled in Diabetes" was read by Dr. Robert Emmet Allen of the Institute's staff. (Promised for publication in the Journal.) The enlightenment on the treatment of diabetes was much appreciated as was Dr. Allen's hospitality in making the Institute available for the meeting and a rising vote of thanks was given with spontaneity.

PASSAIC COUNTY

Leon E. DeYoe, M.D., Secretary

The December meeting of the society was held at the Chamber of Commerce rooms on Thursday, 13th, at 9 P. M.

The subject of the evening was the New Jersey State Medical Society's Insurance Contract. Dr. C. C. Beling, Chairman of the State Insurance Committee was the speaker.

Dr. Beling spoke of the need, the gradual formation of the plan for the present Insurance Contract. He stated that the U. S. Fidelity and Insurance Co. had been granted the contract because their terms were better, their contract is satisfactory. He read a letter from the attorney for the State Society, Mr. Wall, stating that the contract was an excellent one from the legal point of view, stating that the protection against malpractice was adequate.

Drs. W. B. Johnson, J. C. McCoy also strongly urged all members to insure under the State Society contract.

Dr. Beling answered all arguments advanced and firmly convinced all members that the insurance offered by the State Society's contract was the best available for medical practitioners.

SALEM COUNTY

William H. James, M.D., Reporter

The Salem County Medical Society held its December meeting in the Memorial Hospital, Salem, at 2.30 P. M., December 22nd, 1923.

The meeting was called to order with Dr. Franklin H. Church in the chair.

After finishing the regular business of the society we had the pleasure of hearing Prof. Thomas Klein of the University of Pennsylvania, who spoke on "Rheumatism, Endocarditis, and Local Infection." The paper was ably discussed by Dr. Chas. P. Noble of Philadelphia. At the conclusion of the discussion a rising vote of thanks was given Drs. Klein and Noble for the part they had taken to make the meeting a success.

Dr. R. M. A. Davis gave a report from the Welfare Committee. Dr. Church gave a interesting report (he being a delegate) from Camden County Society.

There were 17 members present, including delegates from Gloucester County—Drs. Ashcraft and Downs.

The next meeting will be held February 13, 1924, at the Memorial Hospital.

Local Medical Societies

Bayonne Medical Society.

The Bayonne Medical Society met at the Elks' Club on November 19, 1923, Dr. Sidney Chayse presiding.

The following case reports were given:

Dr. M. Frank, a case of rat bite fever, having an intermittent fever with a rise every five days, lasting 24 hours. The case was cured with salvarsan. Dr. W. W. Brooks spoke about the various types of anesthetics used at the Mayo Clinic. He also reported two cases of acute abdomen. One a case of ruptured intestine following five weeks after an operation for incarcerated hernia, the second

one of acute obstruction due to adhesions between the small bowel and an old appendiceal scar. Dr. Brady, two cases of apparent mild scarlet fever, which had marked sequellae of heart and kidney disease.

Dr. L. J. Ferenczi of the Standard Oil Co. read a paper on the common conditions arising among the workers in the oil industry. He specially mentioned, various degrees of asphyxia due to fumes of oils in closed places like tanks, chemical conjunctivitis, conjunctivitis due to strong light, among acetylene workers and electricians, caustic and acid burns, boiler makers' deafness, tuberculosis, acne and boils, eczema and psoriasis, backache and sprains of the muscles of the back. "About 90 per cent. of the backache in industry are due to bony defects found in the sacroiliac region," and various injuries due to accidents. He outlined the type of general care given the workers, the periodical examinations, the work done on suspected tuberculous employees and the rehabilitation work done on the injured employees.

Dr. J. W. Harvey of the Tide Water Oil Co. read a paper on "The Function of the Physician in Industry and His Relation to the Practitioner." He surveyed the development of the industrial physician, and the reasons for his growth. He is convinced that "a physician in industry can only attain the greatest degree of success when he considers the health and welfare of the employee first." "The pre-eminent sphere of the physician in industry is preventive medicine. Second in importance is rehabilitation." "The physician in industry is in reality a director of medical activity," in other words, "the health officer of the employees." "He should be the chairman of the committee on sanitation and hygiene." He took up in full detail the plans that both the Standard and Tidewater companies follow up, keeping a sick employee on one-half pay for from six to seventy-eight weeks, depending on the length of service with the company.

These papers were very well received and enjoyed by the members of the society. They were discussed by Drs. Forman, Weiss, Sexsmith, Larkey and Axford.

December Meeting.

The following cases were reported at the December meeting of the Bayonne Society:

Dr. Ernest Thum: A case of new growth of the iris. This tumor mass had been presented without much growth for a great many years. A few months ago it began to grow rapidly and was diagnosed as a cyst. In time the tumor occluded the pupillary area. An exploratory operation was done and a portion of this solid mass was removed, which proved on examination to be a melano-sarcoma. The patient refused to have the eye enucleated.

Dr. L. F. Donohoe: A case of torsion of an ovarian cyst, diagnosed before operation. The ovary and adnexia were gangrenous, the gangrene extending into the cornu of the uterus.

Dr. R. S. Woodruff: Mammoth bilateral renal calculi. These calculi have practically filled the renal pelvis on both sides, as shown by the x-ray plates. He discussed the difficulties of treatment in this type of case. A case of pyuria in a girl of 20 years which had existed since birth. X-ray was negative for

stone. Specimens from both ureters were clear. Functional output was 25 per cent from right kidney and 10 per cent from the left. Pylegram showed peculiar shaped pelvis on the left, no calices showing. A second cystoscopy showed pus issuing from the left ureter when the catheter was inserted a short distance, the urine however becoming clear when the catheter was inserted a farther distance into the ureter. The diagnosis was that of a bifurcation of the ureter, one portion going to the pyonephritic lower pole of the kidney. This was proven on operation. A case of bilateral kidney stone in a patient who had been under treatment for a chronic prostatitis. Another case of chronic prostatitis, who complained of pain in his side with chills. A cystoscopy discovered pus issuing from the left ureter and a lack of function on that side. Operation disclosed a pus kidney on the left. A case of hematuria with marked pain in left side. On study of this case, x-ray examination was negative for stone, there was a lessened function on the left and blood issued from the left ureter. The Wassermann was four plus. This condition cleared up under salvarsan.

Dr. G. H. Sexsmith: A case of dislocation of the symphysis pubes. He removed the cartilaginous layer and inserted a wedge of bone taken from the tibia. Pregnancy occurred which was followed by a normal delivery. X-ray after delivery showed a partial bony union present. On sacrum was a shadow indicating the possibility of some slipping of the sacroiliac synchondrosis, which had produced a shortening of about three-quarters of an inch.

Dr. L. M. Klugman: Showed a case of compound, comminuted fracture of the proximal phalanges of the left thumb and middle fingers. He presented the case to show the possibilities of allowing nature to attempt repair, rather than immediate amputation.

Summit Medical Society.

William J. Lamson, M.D., Secretary

The monthly meeting of the Summit Medical Society was held at the Canoe Brook Country Club on Friday, November 30th, at 8.30 P. M., Dr. Dengler entertaining, and Dr. English, Vice-President in the chair.

Present: Drs. Alexander, Bebout, Bowles, Campbell, Dengler, English, Falvello, Keeney, Krauss, Lamson, Meeker, Meigh Milligan, Moister, Morris, Pollard, Praeger, Smalley, Tator, Tidaback and Wolfe..

The paper of the evening was read by Dr. Harvey Ewing of Montclair, on "Modern Methods of Diagnosis of Heart Disease." Special attention was directed to the cardiograph and its value in detecting certain pathological states not otherwise ascertainable. It does not, by any means, tell the whole story, however, but is a valuable aid to clinical diagnosis. It is particularly helpful in diagnosing the arrhythmias, various degrees of heart block, myocardial diseases, and the effect of digitalis therapy on the heart muscles. The paper was illustrated by many cardiographs, which were explained and interpreted by the speaker.

The Golf Committee reported that Dr. Bowles had won the golf tournament, held last summer, with Dr. Moister "runner-up."

Rutgers' Medical Club.—The club met in the College Alumni House December 13th, nearly all the members present with six guests from Perth Amboy and Metuchen.

Dr. Fred L. Brown in the chair. He introduced Dr. Clarence R. O'Crowley of Newark, who read an exceedingly interesting and instructive paper on "The Diagnosis of Surgical Kidney," which was well illustrated by lantern slides.

After discussion the members and guests adjourned to Dr. R. L. McKiernan's home, where Dr. O'Crowley and wife were guests and a social time with refreshments was enjoyed.

American Association for the Study of Goiter.—The annual meeting of this society will be held at Bloomington, Ill., January 23-25, 1924. An unusually full and interesting program has been issued. Several Operative Clinics will be held. A banquet will be held January 24th, at 7 P. M. at the Illinois Hotel, which is the Association's Headquarters.

Academy of Medicine, Northern New Jersey.

Stated meeting January 16th, 8.45 P. M. Paper by Dr. Royal S. Copeland, U. S. Senator, New York, on "The Doctor and the Future."

Section on Medicine and Pediatrics, January 8th, 8.45 P. M. Paper on "Hypotension," by Dr. Harold Brooks, New York, discussed by Dr. M. J. Synnott.

Section on Eye, Ear, Nose and Throat, January 14th, 8.45 P. M. Reports of cases. Paper by Dr. C. H. Schlichter, on "Observation on the Use of Radium in Cataracts," discussed by Dr. S. T. Quinn.

Section on Surgery and Obstetrics, January 22nd, 8.45 P. M. Report of cases. Paper by Dr. Max Danzis, on "The Present Status of Gall Bladder Surgery, with Report of 140 Cases," discussed by Drs. E. J. Ill, G. A. Rogers and M. Asher.

Meetings held in rooms, 91 Lincoln Park, Newark.

The A. M. A. State Medical Licensing Boards

The report of the Executive Committee of the A. M. A. says: If State medical licensing boards would admit to examinations only those qualified by education to be physicians while police powers of the States were directed to search out and prosecute men practicing medicine without a license, the nation would be freed of unqualified doctors, the American Medical Association declared today in an official statement by its executive committee.

The statement said that the number of medical imposters and poorly qualified physicians in the country, "does not even approximate 25,000," the number claimed by a man under indictment for diploma frauds in Missouri. It set out that during the last eight years, not more than 2,500 graduates of low-grade medical schools have received licenses. "For more than twenty years, the attention of the public has been regularly directed, in official publication of the association to various evils," the statement declared. "Ever since 1918, the Journal of the American Medical Association has published annually the fact that the Connecticut and Arkansas Eclectic licensing boards were apparently serving as clearing houses for low-grade institutions in Missouri.

"In 1920 the journal pointed out that Connecticut, through its eclectic board, was licensing men who had not studied in eclectic medical schools, and even worse, was licensing some men who had not apparently completed a medical course in any school. Nevertheless, public officials have consistently disregarded these announcements until the sensational publicity accorded an expose by a St. Louis newspaper forced the matter on their attention. There are today five medical schools in the United States which are not up to the high standard of the remaining seventy-six. If these schools are forced to raise their requirements or else discontinue, the public will be assured that no men will be graduated in medicine who are not qualified to appear for licensure. If the State licensing boards will then admit to their examination only those qualified the public will have assurance that any man who can present the license of the State examining board is a properly qualified physician."

The medical profession definitely disclaims the function of searching out and prosecuting the man practising medicine without a license, the statement said, adding that belongs to police powers.

The report is signed by Doctors Frank Billings of Chicago; A. R. Mitchell of Lincoln, Neb. and Charles F. Richardson of Washington, D. C.

Antiquack Legislation in New Jersey.—The State Board of Medical Examiners of New Jersey announced, December 18th, that legislation to weed out the quacks from among the medical practitioners of the State would be proposed to the 1924 legislature. The board will recommend measures that will prevent persons unable to meet the State requirements from obtaining a license, that will force medical institutions to get the approval of the State board before obtaining charters, and that will require interns to pass an entrance examination.

Menace of "Medical Mills" Is National in Scope.

A formal movement in Missouri to relieve three medical schools in St. Louis and Kansas City of their charters, following a survey of their fitness to teach the science of healing, culminates a fortnight's revelations started by the Connecticut "medical mills" inquiry. Of six medical schools in the "show me" State, three received a clean bill of efficiency, and all three are directly connected with general universities.

That is significant in itself. When Abraham Flexner made his country-wide study of our medical colleges a few years ago his findings might have been summed up in the statement that no institution for the teaching of medicine and surgery could fulfil its obligation to humanity and its students without broader connections than were then possessed by most of the then existent institutions. The exceptions were the university schools, headed by the Johns Hopkins, and the primary requisite was one that enforces its own logical connection, possession of a general hospital on the highest plane, with full laboratory equipment.

Simultaneously with the Missouri action toward revoking charters, Connecticut moves to force eighteen men practicing as physicians to surrender their licenses. Indications are that this is but a beginning. Evidence contributing toward this decision has included the showing that the products of the medical mills permeate our army, navy and public health establishments, have positions as ships' doctors on some of our liners, and otherwise ramify through out medical ranks. At the same time an inquiry in New York brings out assertions of wholesale fleecing of newcomers to our shores by "health institutes" and unethical practitioners of medicine. Instances are offered in which their activities have resulted in needless fatalities, including suicides caused by the belief that the self-destroyers were afflicted with diseases which they did not have. And while a medical college under the shadow of the Johns Hopkins itself is brought under scrutiny by the Connecticut inquiry, Baltimore moves to prosecute a widely-ramifying syndicate of doctors.

This is a national situation, the menace of which can only be conjectured. Clearly it requires not only general vigilance, but also the carrying forward of the present inquiries to the final point of eliminating conditions which endanger the lives of the people.—Newark Evening News.

Miscellaneous Items

The General Practitioner.

The common doctor, who has spent thousands of dollars in his education, is beset on all sides by cultists who are on the whole uneducated and untrained men. These cultists actually receive more money for their various drugless treatments than the honest honorable physician who is trying by methods, which we confess are not always exact, but methods which have stood the acid test of time. A Christian Science healer receives more for a prayer than a physician receives for an intelligent prescription that cures—The Medico.

Parent and Offspring.—When one parent is feeble-minded and the other epileptic, the results are commonly still more disastrous. In fifteen matings of this kind studied by Davenport and Weeks, twenty-eight of the fifty-five offsprings were epileptic, twenty-six were feeble-minded, and one was insane.—Holmes: *Studies in Evolution and Eugenics*, New York.

Infrequency of *Tabes Dorsalis* in Siam.—It may be safely be estimated that between 80 and 90 per cent. of the male population in the cities suffer from venereal infection at some time, and only to a less degree in the country. Certainly more than half the females become infected before they reach the age of 21. We find eye complications that vary all the way from complete blindness to slight visual incapacitation. Sterility, invalidity of various degrees and kinds and the other venereal complexities, primary, secondary and tertiary, are common. Of many thousands of patients examined during the last five years, only two cases of *tabes dorsalis* have been recognized.—R. W. Mendelsohn: *Am. J. Pub. Health*.

Tuberculosis Cure in a Worm.—A simple worm, scientifically known as "*Galleria mellonella*," may be the salvation of millions of humann lives, according to the conclusions of Professor Metalnikov, Russian savant of the Pasteur Institute, after experiments lasting since 1908. The "*Galleria mellonella*," according to Metalnikov, is the only living thing absolutely immune to tuberculosis. From its blood the Russian scientist is now engaged in producing an anti-tubercular serum on which the famous Pasteur Institute pins high hopes.

In 1920 Metalnikov prepared a culture of tubercule microbes at the highest degree of virulence. He injected the fortieth of a cubic centimeter of this culture into the worm, corresponding to a quart and a half of liquid injected into the veins of a human being. If such an injection had been made into the veins of a man he would have died in short order. But the worm seemed to like the microbes. He evinced not the slightest sign of a malady.

The Thyroid Gland Emerging from Obscurity.

Books of reference published within the last decade note the thyroid gland as possessing functions whose nature is "still not entirely understood." But of late such knowledge has become more definite. It appears likely that the day is not far distant when the thyroid will be put to definite use in the controlling of stature. Under the most dignified auspices it has been declared that so-called dwarfs—cretins, in the terminology of pathology—have been made to grow taller by the use of extracts of the thyroid. Cretinism is a condition brought about through insufficient thyroid solution; its cure, it is claimed, is a matter of balancing the supply. Before the Congress of the American College of Surgeons in Chicago cases of such lack of glandular effectiveness have been subjected to clinical treatment with actual increases in stature brought about through injections of the thyroid liquid of goats. In the calf the thyroid becomes the sweetbread of the epicure. Specifically, the word means shield shaped, which is the physical characteristic of the gland now becoming better understood by scientists.

Obstetric Patience.—Patience in obstetrics is next to asepis, but it must be the active patience of ignorance, allowing the mother to become totally exhausted or the baby in imminent peril of death before determining on a line of action.—J. A. Harrar: *Bull. Lying-In Hosp.*

Diet as a Cause of Constipation.—Unbalanced dietary is a cause of constipation. The effect of this condition is seen most often in infants, but its results are often very noticeable in adults as well. It always results in portal congestions, and eventually in colitis.—R. M. Clarke, California State J. M.

Inside Information: Paris, Aug. 6.—The Figaro announces that the king and queen of Jugo-Slavia have postponed their state visit to the French republic until March, 1924, as the queen "will give birth to a son, the crown prince," early in September.

(The Figaro does not explain how the royal couple know the expected child will be a boy.)—Chicago Tribune.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

CHAS. D. BENNETT, M. D., Chm., 177 Clinton Avenue, Newark.

JOHN B. MORRISON, 97 Halsey St., Newark.

EDWARD J. ILL, M. D., 1002 Broad St., Newark.

DAVID C. ENGLISH, M. D., Editor, 65 Paterson Street, New Brunswick.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

HAVE YOU PAID 1924 DUES?

After January 15th members whose dues have not been received by Treasurer Marsh of the State Society are reported to the State Society and the American Medical Association as delinquents, and their names will not appear in the Official List published in February.

County Treasurers should make early and continuous effort to collect dues and should send late paid dues immediately to Treasurer Marsh.

VOLUME XX.

The Volume for 1923 closed with the December Journal and the Editor thanks all officers and members of the State and County Societies who assisted him in making it the best volume we have ever issued according to the judgment of many members whom we thank for their kindly expressed words of appreciation.

VOLUME XXI.

The Editor in endeavoring to improve the Journal from year to year realizes that it has not yet met his own conception of what a State Society's Journal should be and it will be his endeavor to make Vol. 21 far superior to any of the previous volumes. We will welcome any suggestions that will

aid us in doing so. Next month we will give notice of some changes we have suggested and the Board of Publication has approved, but we urge now the secretaries and reporters of our County Societies to keep us better informed of the meetings and work of their respective societies, and we shall always welcome information and assistance from any of our members that will enable us to set forth the activities of our profession in New Jersey.

Is a doctor who is not prompt very reliable? How about your dues?

EDITOR'S PERSONAL WORDS.

The Editor most heartily wishes every member of the Society and every reader of the Journal a very

Happy New Year

It is his positive conviction that it will be exceptionally happy if each will adopt the same method of making it sure that he has for himself, as follows:

Thankfulness for the great privilege of serving our State Society in past years; spending many hours recently in thoughtful study and planning how to render better service during the year 1924. The desire for such a result has risen largely from reflections on three occurrences during the last three months:

1. The remarks of Judge West—recently elected State Senator—made at the annual meeting of the Gloucester County Society, in substance as follows: That from his study of the medical profession and his observation of its work, he believed it was the most unselfish profession or body, of men in the world.

2. The presentation of the Tablet in memory of Dr. McKean, founder of the State Society in 1766 and especially of the Society's Constitution's definition of its work as being for "Mutual Improvement, Advancement of the Profession and Promotion of the Public Good."

3. The appointment of Dr. Andrew F. McBride as State Commissioner of Labor and the great pecuniary sacrifice he made in accepting that office.

We might refer to the sacrifices made by our President, Dr. Eagleton, his predecessor, Dr. Hunter, and many other officers and members of our profession have made and are constantly making, as demonstrating that to the members of the profession

LIFE and OFFICE means SERVICE regardless of pecuniary reward. *Giving of Time, Money, Influence*, not *Getting* for self-enrichment.

We commend that as the sure method of making the New Year Happy.

Since the above editorial was written we have read an editorial on "Medical Publicity" in the December issue of Colorado Medicine. We give our readers the following extracts therefrom:

It is Mr. George A. Collins, the non-medical man, who appears and from a pulpit of one of Denver's churches says among other things: "Friends, we have one hundred and fifty physicians on the county hospital staff, many are leaders, nationally recognized authorities in their specialties, and these men and women give the city their time, their best thought, their skill, without being paid one single cent. I could tell you of a great many incidents of personal sacrifice, but will tell you of but one. and women gave unstintingly of their time when they could have been making money During the 'flu' epidemic these staff men in private practice. One man who has grown gray on the county hospital service, was on medicine at that time. He refused to take new pay cases and just called on his old patients, and gave us at the county hospital practically all of his time; he was there mornings, came every afternoon and was on call all night. All this, as I have said, without one cent of pay except the satisfaction of doing what he could for humanity and his profession. Talk of civic benefactors, why, oh, why, forget the men and women of the county hospital staff and their unselfish devotion to the needy and sick?"

As a profession we are so used to give freely of our time and skill, just as a matter of course, that the words uttered by Mr. Collins sound to us almost like flattery, yet, they are all but that. The truth of the matter is that we render free services more than any other existing profession. * * * * The giving of service gratis is not characteristic of the county hospital staff alone; it is typical of the rank and file of the entire medical profession. * * * * Wholesome and ethical publicity is a thing the profession needs. When something of this nature comes from an outsider, it is that much more desirable. As a profession we are the most paradoxical lot living. We keep ourselves dignified and aloof away beyond the

point of normal, yet we are too modest to proclaim, in the least, our achievements. The result of it is that the people have a skeptical attitude toward us instead of one of confidence. * * * *With both scientific medicine and the truth back of us, need we fear that we are advertising?—L. V. T.

ACADEMY OF MEDICINE.

The Academy of Medicine of Northern New Jersey has been greatly enriched by the generous gifts of Dr. Edward J. Ill, the first President of the Academy and a Fellow of our State Medical Society. He donated bound volumes of the Journal of the A. M. A.; the Obstetrical Journal; the Amer. Jour. of Medical Sciences; the Annals of Surgery; Jour. of Obstetrics Surgery and Gynecology; about 4,000 reprints and 100 volumes of medical lore all over 200 years old, with the necessary cases and files for their proper and accessible use. In addition thereto he donated \$1,000 to the "Library Fund," the interest therefrom to be expended for the continued subscription and binding of the above mentioned journals. We congratulate the Academy on the loyalty and generosity of such present and past members as Edward J. Ill and the late William S. Disbrow.

TO WRITERS OF MEDICAL PAPERS

We take the following editorial from the June 28 issue of the Boston Medical and Surgical Journal and commend it to the very careful consideration, not only of the writers of medical papers, but also of the secretaries and reporters of county medical societies. The latter seem to forget very often that typesetters are not medical men, and, therefore, are unacquainted with medical terms and authors' names and, therefore, if copy sent is indistinctly or incorrectly written, they make mistakes. Copy sent should either be typewritten or very carefully and distinctly hand written. The Boston editor says:

"It is a question whether writers of medical papers realize the responsibility that rests upon them when they quote the work of others. This does not end with the publication of an article of research or a case report. The importance of clarity of expression and simplicity of language has been emphasized amply in the past. Recently attention has been drawn to the gross carelessness that exists among American writers in regard to exact quotations, proper spelling of authors' names and proper references in their bibliography.

"Probably in no single country does such a state exist to the same degree as it does here. A very few of the American medical publications verify such references, and these are to be thanked for the hours of labor and careful search they have spared other investigators. In a recent extensive bulletin no less than eight references out of twenty-eight were wrong, two authors' names were spelled incorrectly and two articles were quoted that had no reference whatsoever to the text of the author's paper.

"This is a matter that writers should consider seriously. If criticism is to be avoided as to the author's faith and honesty or unless writers wish to shake the faith of the reader in the reliability of the information presented, greater care must be shown in respect to the work of others. Let this matter be remedied now before we earn a name for which we shall have only ourselves to thank. Let the writer realize his responsibility and be fair, courteous and above all accurate.

THE PASSING OF GREAT MEN IN THE PRACTICE OF MEDICINE

Jour. Iowa State Med. Soc. Editorial

We may date the beginning of modern teaching of scientific medicine in the United States with the organization of the Johns Hopkins Medical School. There was a growing spirit of modern teaching but until the foundation of Johns Hopkins there had never been funds for the purpose. When Wm. H. Welch returned to New York in 1878 after his long training in the hospitals and laboratories in German, he found no laboratories in the New York Medical Schools or Hospitals. He was appointed lecturer in pathology to the College of Physicians and Surgeons but there was no laboratory. This did not meet with Dr. Welch's views. The newly organized Bellevue Hospital Medical School offered in addition to a lectureship two small rooms over a hallway and an additional room which he could turn into a laboratory. This seemed but a small way to begin pathology after years of work and study in the fine laboratories of Europe. In 1885 Welch was made professor of pathology at Johns Hopkins Hospital but it was not until 1888 and 1889 that the medical school was organized and the faculty appointed. Of Halstead, Osler and Kelly, the first three great teachers selected by Dr. Welch, Howard A. Kelly only remains. Dr. W. S. Halstead

was born in New York September 25, 1852 and died in Baltimore September 7, 1922 in his seventieth year. He was a graduate of Yale, 1874, and the College of Physicians and Surgeons, Columbia, 1877. Honorary F. R. C. S. England, 1900, and from Edinburgh in 1905. He was connected with several hospitals in New York until 1889 when made professor of surgery, and surgeon-in-chief of Johns Hopkins Hospital. Welch Halstead and Kelly are names that will always be associated with scientific medicine in America.

THE DOCTOR'S CONSCIENCE.

There has never been a time in the practice of medicine when the profession has been more disturbed by the various laws, rules and regulations of the State and National governments, as well as the other irritating social conditions, which render the life of the average doctor one full of trouble.

It is a well-known fact that since the earliest days of medicine, the conscience of the medical practitioner has been ruled by his desire to be honest, truthful, upright and conscientious in his dealings with his patients. This applied even to some of those who were not overscrupulous in other matters, for which their patients honestly and conscientiously prevailed.

The conditions now existing offer a great temptation many times to submerge the conscience and obliterate from our minds the need of rectitude in our various reports in the observation of the laws and rules which are so confusing. It is not an easy matter to practice medicine in the present day. It is much easier to feel that we are still free moral agents to do as we like, thereby disregarding often the imposed duties which carry penalties with them.

Our conscience should still be our guide in dealing not only with our patients, but with the various other agencies that confront us. The federal government is placing more and more restrictions about the practice of medicine in the form of laws, rules and regulations affecting the prescribing of drugs and the writing of prescriptions for those who are ill. The department of the state in the health regulations is requiring more and more attention, all of which rankles in the minds of the profession as being unnecessary and burdensome.

We hope that the conscience of the medical practitioner will not be dulled or obtund-

ed to the extent that the general public will begin to recognize us as desiring to align ourselves with the hosts who are disobeying and violating every one of the enactments which place them in the outlaw class. We have too much at stake. We should have sufficient reverence for our past history and traditions not to stain it by thought or act. Every misstep of any individual in the profession brings a stigma upon organized medicine.

Let your conscience be your guide and make that conscience behave. — Atlantic Med. Jour.

LAY CONTROL OF MEDICINE

Lay control and dictation of the management of the institutions in which medical men are interested directly or indirectly is bound to come unless something is done to prevent it. Not alone this, but lay control of everything pertaining to the practice of medicine eventually will come unless the spinless doctors who fail to see the growing tendency of the times awoken to the danger and put on their fighting clothes in an attempt to save a reasonable amount of independence for themselves. This is no idle dream, and those who think differently will have occasion to learn the truth perhaps when it is too late.—Indiana Medical Journal.

CAMPAIGN AGAINST CANCER.

The American Society for the Control of Cancer planned for the campaign for this season. Instead of a single National Cancer Week there was a series of six cancer campaigns, one month being devoted to the subject in each of six regions in the United States and Canada. Three weeks were devoted in each region to the making ready for the campaign, the fourth to be devoted to carrying out the activities.

This great movement is the expression of the determination of the profession and the laity to save as many people as possible from horrible suffering and death. The conquest of cancer thus far depends upon its early recognition and the employment of indicated treatment. The campaigns of education in the past have saved many lives, as shown by the considerable number of people who have consulted physicians for growths that have up to the time of submitting to medical supervision shown very little evidence of malignancy.

Every physician and every other intelli-

gent person should be allied with this movement in order that the accepted facts relating to malignant diseases should be common knowledge, to the end that competent treatment may be applied before the hopeless conditions may have developed.

Save the cancer patients from the results of ignorance and the quack!

In general, those things which are gratuitously furnished to the public are mediocre in quality; indeed anything which is "free" is justly looked upon with suspicion. Attempts to compromise the medical profession by petty generosity are constantly evident in the practitioner's office. His pencils, blotters, and medical supplies are always contaminated with advertisements which may infect a passing patient before they reach the waste basket. The physician himself usually acquires an immunity to them, and very soon learns that a price must be paid for most products of value.

ETIOLOGICAL STUDY OF ANESTHETIC DEATH

Bifiku Tokumitsu, in the Tokyo Medical News, reports having examined the biological attitude of chloroform and ether, and discovered that the former affects not only the central nervous systems but also the functions of the suprarenal glands, for it lowers both the blood pressure and the secretion of adrenalin, and it affects the central nervous system as the former. Thus if chloroform should be administered to those cases having defects in the suprarenal glands, e.g., thymicolymphatic constitution, it would immediately endanger the life of the patient.

THE DANGER OF CHIROPRACTIC.

From the N. Y. Tribune

The District Attorney of Kings County has in hand the case of a girl who is said to have died of diphtheria under chiropractic treatment. If the facts are as reported here is a concrete instance of the fatal blunders to which chiropractic is liable.

The sincere practitioners of this cult do not, if we understand their claims, profess to be able to cure diphtheria, nor does the law permit them to attempt it. Yet they pass as "Dr." Smith and "Dr." Jones, virtually inviting a general practice. Many chiropractors, perhaps the majority, are unable to recognize cases of diphtheria or other communicable diseases. In their ig-

ignorance they try their spine adjustment on patients who should immediately be placed in the care of a physician.

Two measures seem essential if the chiropractors are not to be a continuing menace to health and life. They should in the first place be forbidden to pass as doctors, which means by common acceptance physicians. Few persons in the event of serious illness would intrust themselves or their children to a chiropractor if they were not misled by the impression that he was a doctor. Secondly, no chiropractor should be permitted to practice his specialty who has not proved under adequate examination that he is competent to diagnose disease. In addition his character should be so attested as to remove every reasonable doubt that he will transfer to regular physicians all cases that do not fall within the limited field of chiropractic.

At present the cult is running wild and is a menace. If it is not to be outlawed in New York State it will have to be brought under proper regulation. The out-and-out charlatans could be removed by rigorous licensing, and the activities of the honest chiropractors who have met a required standard of training so circumscribed that the likelihood of doing serious injury would be minimized. But the physicians have a right to be heard in the matter, and the Legislature should give due weight to their testimony.

SMOKING AND BLOOD PRESSURE

Among the habits that almost invariably are interdicted by the physician in the treatment of illness is the smoking of tobacco. Heretofore this interdiction has been based on a large empiric observation, but not founded on any extensive scientific study. In the course of a series of investigations on the effects of cigars and cigaret smoking on certain psychologic and physiologic functions, Dr. Robert L. Bates of the Psychological Laboratory of the John Hopkins University has made a number of observations on the effects of tobacco smoking on the systolic and diastolic blood pressure and on the heart rate. Readings were made over a long interval on volunteer students, who were seated comfortably and smoked extensively during the observations. The tests indicated briefly that, following the smoking of a cigar or three cigaretts, there is a rise in systolic and diastolic blood pressure and in the heart rate. The rise in blood pressure usually amounts to only a

few millimeters, and, as Dr. Bates remarks, "The normal irregular variations in blood pressure, due to various causes, are practically as great as the variations which may be ascribed to tobacco." The rise in heart rate is irregular: usually less than 10 a minute in most cases, but in some cases as much as 20. Both blood pressure and heart rate subside to normal in from twenty to thirty minutes. The report of this study concludes with the statement that the extent to which the effects are due to absorbing smoke products and to psychologic factors involved in smoking remains to be discovered. The observations are of interest and indicate particularly the great difficulty in arriving at scientific conclusions in investigations of this character.—A. M. A. Journal, September 1st.

TOO LAZY

"If I were to name the one chief cause of surgical failure, in almost every case it would be laziness. Too lazy to take pains, too lazy to read books and journals, to visit hospitals and clinics, to attend medical meetings, to learn the newest and best methods. I have said long ago that a lazy man had no business to be a surgeon." Colcord, Pittsburg Med. Bull.

This indictment, by a great surgeon, of his fellow surgeons, could be stretched to include all branches of medical practice. Who are the men who are NOT found in the medical society meetings? They are the men who have gotten fat and complacent, who consider their knowledge is far superior to that of their confreres, that they can learn nothing in the county society meeting. This class and the still more ridiculous doctor who, recently out of college, feels his oats to such an extent that he is entirely self-satisfied, are the ones who cannot find time to attend serious discussions of medical matters.

Too lazy to read! We recently observed a supposedly well-informed doctor making surprised inquiry about a method of treatment which has been in the current medical literature for two years or more. He had never seen it!

Too lazy to visit hospitals and clinics! There is not a doctor living who can keep well informed by reading and practice alone. Yet many a prominent surgeon and physician has not spent a month in clinic observation in five or ten years.

Too lazy to attend medical meetings! His license should be revoked. He CAN-

NOT be sufficiently well informed to take the lives of people into his hands.—Southwestern Medicine.

THE GREATEST THERAPEUTIC NIHILIST

The greatest therapeutic nihilist is the foggy physician who rejects the teachings of bacteriology and public health, who refuses to give immunizing doses of diphtheria antitoxin or the toxin-antitoxin, who refuses to vaccinate against smallpox and typhoid, who fights reasonable quarantine measures, who does not believe that malaria and yellow fever are mosquito-born, and who thinks that syphilis and tuberculosis must be tolerated rather than be cleaned up by a campaign of prevention. Such physicians, even though estimable men, are positive menaces to the public health.—The American Physician.

Rockefeller Foundation Gives Millions.—Appropriations totalling \$2,750,000 for the benefit of four medical schools were announced recently in a Rockefeller Foundation report, in which it was said the organization's commitments for the year 1924 already totaled \$10,500,000. A balance of less than \$1,000,000 remained available for 1924 appropriation from the regular income, the report added. The newest appropriation included \$1,000,000 to the University of Chicago medical school, \$225,000 to the medical school of the University of Iowa, \$1,000,000 to the University of Toronto medical and \$500,000 for endowment of the medical school of the University of Alberta, Canada.

MEDICAL SOCIETY OF NEW JERSEY

New Members

Donahoe, William J., 71 So. 9th st., Newark
Margulis, Borts, Hawthorne av., Newark.
Pyle, Weldon, Irvington av., East Orange.
Rogers, Richard M., Wallace st., Newark.
Schaaf, Edward O., South Orange av., Newark.

Reinstated Members

Doriss, H. Stokes, So. Florida av., Atlantic City.
Fuerstman, Herman L., 570 High st., Newark
Herndon, Lewis S., 79 Lincoln Park, Newark.
Kremens, Maxwell B., Clinton Apts., Atl. City.
Parsonnet, Aaron, 3 Madison av., Newark.
Pennington, John, Kenapac Apts., Atl. City.
Rohn, John P., 789 Clinton av., Newark.
Stalberg, Isaac Z., Pacific av., Atlantic City.

Hospitals; Sanatorium.

Greenville Hospital, Jersey City, is to have an addition erected to its buildings to cost \$90,000.

Linn Memorial Hospital, Sussex.—This hospital will receive \$500, bequeathed by the will of Mrs. Mary J. Clark of Sussex.

Somerset Hospital.—Bids for the construction if the new hospital will be received this month. It is estimated the building and furnishings will cost about \$400,000. Of this \$235,146 has been pledged and about \$100,000 has been paid in. The hospital has had the best year of its existence.

South Orange Convalescent Hospital.—Plans have been completed for a \$200,000 hospital there.

New Hospital at Vineland.—A large number of physicians inspected the Newcomb Hospital at Vineland on December 28th and the opening exercises were held on the 30th with an address by Ex-Governor Stokes. The hospital building is the gift of Attorney Leverett Newcomb of that city.

Bonnie Burn Sanatorium.—Dr. John E. Runnells, superintendent, reports that on October 31st there were 252 patients in the Sanatorium, 140 males and 112 females. This included 61 children in the Preventorium. Since the last report 31 patients have been admitted, 13 males and 18 females. Fourteen of these admissions went to the Preventorium. Among these admissions were ten re-admissions. The admissions are classified as follows: Pretubercular, 14; incipient, 2; moderately advanced, 3; far advanced, 12. Present November 29th, 253. This number includes 75 children in the Preventorium, and 76 out of the county patients.

Deaths.

BOWMAN.—In New York City, November 28th, 1923, suddenly, Dr. J. Floyd Bowman of Irvington, N. J.

Dr. Bowman was born in Paterson June 12th, 1879. He prepared for college at Montclair High School and Brooklyn Polytechnic Institute and was graduated from Columbia College in 1900. He entered the College of Physicians and Surgeons of New York and was graduated in 1904. After serving two years as intern at Bellevue Hospital, New York, he practiced at Bradford, N. Y. He moved to Irvington in 1908 and from 1913 to 1915 he was police and fire surgeon of the town. In 1916 he gave up his general practice and thereafter confined himself to specializing in treatment of eye, ear, nose and throat. During the war he joined the medical corps as first lieutenant, serving at Fort Ethan Allen, Vermont, and Fort Totten, Long Island. When the war ended he returned to Irvington and continued to practice.

Dr. Bowman was for several years a member of the first staff of the Presbyterian Hospital of Newark, was on the consulting staff of the Irvington General Hospital and for many years was an assistant surgeon at the New York Eye and Ear Infirmary. He was clinical ophthalmologist to New York College of Physicians and Surgeons.

Dr. Bowman was a member of the American Medical Society, Essex County Medical Society, Bellevue Hospital Alumni Association, Irvington Council, Jr. O. U. A. M., and the Forum of Irvington.

IN MEMORIAM

Arthur Coles Dougherty, M. D.

Action of the Medical Staff of the Newark City Hospital

Died July 19th, 1923

We desire to call attention in a formal way to the loss this hospital has sustained in the death of Arthur C. Dougherty, M.D., for many years a faithful attending member of the medical staff.

We cannot understand the career of Dr. Dougherty unless we take into account the influence of his father, the late Dr. Alexander N. Dougherty, for many years one of the leading surgeons of St. Michael's Hospital. Dr. Alexander Dougherty was a veteran of the Civil War, Major Surgeon of the late General Hancock's staff and a man of scholarly tastes and wide reading outside of his profession—the son, influenced by his father resolved to follow in his steps, and after a four years' course at the College of Physicians and Surgeons, then situated at Fourth Avenue and Twenty-third Street, he graduated M. D. in the year 1882. He owed much to the teaching of such men as Dr. Alonzo Clark and Dr. Francis Delafield. It is not derogative to him to say that he did not possess his father's great ability in surgery, but was better adapted for the medical field, his sensitive nature forbade him to give pain and his kindly disposition made him many friends. When he returned to the end of his days he worthily upheld the ethical traditions of the profession, and in these days of many changes in the profession, he was above being dazzled by the vision of success achieved at the expense of principle.

RESOLVED, That a grateful tribute of his unselfish service be spread upon the minutes of this hospital.

RESOLVED, That a suitable copy be sent to his bereaved family, as an appreciation of our sympathy.

RESOLVED, That some notice of his service be published in the public press or journals, that the public may recognize his service.

EDMUND H. MADDEN, M.D.

Died November 27th, 1923

The Atlantic County Medical Society at its meeting held December 14th, adopted the following resolutions:

Edmund H. Madden, M.D., died at his home in Absecon, N. J., November 27th, 1923, at the age of eighty. He was the last living charter member of the Atlantic County Medical Society to answer the final summons. Dr. Madden was honored not only by his medical brethren, but was loved by the many families to whom he ministered in their hours of sickness and trouble. As a citizen he always stood prominently for the right and the uplift of his fellow man.

Atlantic County and the Atlantic County Medical Society have lost a most valued citizen and member, whose memory will long be revered and honored.

Resolved, That the Atlantic County Medical Society expresses its deepest sorrow in the loss of Dr. Edmund H. Madden and extends the sympathy of its members to his family and friends.

Resolved, That a copy of this memorial be spread upon a separate page of the book of records of the Atlantic County Medical Society. Philip Marvel, M.D., W. Blair Stewart, M.D., Committee.

DR. EMMA C. CLARK—See page 32.

Public Health Items.

Future of Health Officer.—In these progressive times there is a magnificent future for the medical officer of health. "Prevention is better than cure," and although he will frequently be expected to prevent the unpreventable, and remove the irremovable his opportunities to improve the physical condition of the people will be abundant, and his influence for good on the health of the community enormous. In all circumstances, and on every possible occasion, he should strive to work hand and glove with the practitioners in his district—his work then will be far easier of accomplishment and more satisfactory in achievement than if a state of armed neutrality or open warfare existed between him and them.—E. B. Turner: Lancet.

Newark Health Report.—The report for October shows: 358 deaths or a death rate of 9.8 per 1,000 of population. The principal causes of death were: Tuberculosis, 30 cases; cancer, 39; apoplexy, 24; organic heart disease, 55; pneumonia, 21; Bright's disease and nephritis, 24. There were 890 births during the month.

Newark Health Report: There were 367 deaths in the city in November, or a death rate of 10 per 1,000 population. The principal causes of death were: Tuberculosis, 27 cases; cancer, 34; apoplexy, 29; organic heart disease, 59; pneumonia, 36; Bright's disease, 18; congenital debility and malformation, 31; accident, 23. There were 877 births during the month.

U. S. Infant Death Rates.—The lowest death rate among cities with 50,000 to 100,000 population is that of East Orange, with thirty-four, with Berkeley second with thirty-seven.

Of cities from 25,000 to 50,000 population, Newport, R. I., is low with twenty-eight. Next comes Montclair, N. J., with forty-two and Alameda, Cal., with the same rate as Montclair.

In cities from 100,000 to 250,000 population, the highest rates are reported from San Antonio, with 143; Fall River, Mass., with 126; and Trenton, N. J., with 108.

New Jersey' Death Rate.—New Jersey's adjusted mortality rate in 1922 was 12.3 per 100,000 population, as shown in compilations made by the Bureau of Census. The 1922 death rate in the registered area of the country was 11.8 which was the rate in New Jersey in 1921. The bureau's figures show the following rates for cities in New Jersey: Newark, 12.3 against 11.9 in 1921 and 14.0 in 1920; Jersey City, 13.0

in 1922 and 1921, and 15.4 in 1920; Trenton, 16.3, 13.7 and 16.4; Paterson, 13.4, 13.4 and 13.5, and Camden, 14.4, 13.4 and 15.4.

Only six States, Michigan, Mississippi, Ohio, Pennsylvania, Virginia and Wisconsin show lower mortality rates for 1922 than for 1921. The lowest 1922 state rate (8.1) is shown for Idaho and the highest (14.7) for Maine and Vermont each.

Typhoid Death Rate, Lowest Recorded.—

Last year's death rate of typhoid fever was the lowest ever recorded in the registration area, comprising eighty-five per cent. of the country's population, the Census Bureau announced recently. There were 6,981 deaths of typhoid fever in 1922, as compared with 8,007 in 1921, and 6,805 in 1920. The rate per 100,000 population was 7.5 last year and 9.0 in 1921. There were 128 deaths from typhoid fever in New Jersey in 1922. 147 in 1921. The death rate last year was 3.9 per 100,000 population, 4.5 in 1921.

Physician as Advocate of Health.—The whole-time country health officer comes nearer giving the rural practitioner the same advantages that the city practitioner enjoys than anything else. Every physician should be an advocate of health.—Chichester, P. M.: Virginia M. Monthly.

Death Rate From Diabetes: The Department of Commerce announces over 17,000 deaths in 1922 from diabetes mellitus in the registration area, which comprises eighty-five per cent. of the population of the United States. Within this area the death rate from diabetes per 100,000 population was 18.4 as compared with 18.6 in 1921. Deaths in New Jersey from this disease totaled 711 in 1922 as compared with 641 in 1921 and 594 in 1920. The mortality rate in these years was 21.4, 19.7 and 18.6.

Chicago Stamps Out Blindness in Babies.—Of 56, 724 births in Chicago in 1922, not one case of blindness has developed, it was announced today by the Chicago health department, due to stringent enforcement of the law requiring that all cases of sore eyes in the new-born shall be reported within six hours. Chicago is the one large city that has such a record, the health department added. The institutional cost of supporting and educating a blind child is \$500 a year, the announcement said, which represents a needless expense to the taxpayers.

Health Education of School Children. — The following is from an able paper by Dr. Jesse F. Williamson in the September, 1923, Hygeia: The study of health has been considered a content subject; it has been concerning with offering information. Not infrequently one finds children with serious health defects reciting in poorly ventilated and badly lighted rooms such matter as "the number of bones in the body, the character of the gastric juice, the function of the spleen, the cause of peristalsis."

Contrariwise, it is suggested that what the child knows about bodily processes and health is not very important, but what the

child is and practices are extremely significant. A health survey of the child is the first step therefore in any scheme of health education. What is the evidence?

More than 1 per cent. of pupils have organic heart lesions. From 5 to 10 per cent. of pupils have or have had tuberculosis. From 20 to 30 per cent. of pupils in most schools are malnourished. From 25 to 35 per cent. of pupils have defective vision. From 5 to 8 per cent. of pupils have defective hearing. From 15 to 35 per cent. of pupils have adenoids, diseased tonsils, or other glandular defects injurious to health. From 50 to 98 per cent. of pupils have defective teeth.

Compulsory Inoculation of Dogs with Anti-rabies Virus.—More than fifty-five dogs having gone mad in Newark and surrounding communities within the present year, rabies is epidemic in this area, Health Officer Craster declared today. The number is nearly twice as large as for any previous year, and refers only to dogs whose heads under expert study after death have proved them rabid. December 4 is the probable date in which Dr. Craster, Dr. Richard N. Connolly, city bacteriologist, and Dr. Werner Runge, Health Department veterinarian, will appear before the State Board of Health and urge drastic measures for the control of rabies, Dr. Craster said. This action is in line with recent action by the city Board of Public Safety and with directions given to Dr. Craster by Mayor Breidenbach.

Personal Notes

Dr. Chester R. Brown, Arlington, addressed the Home and School Association of Kearny recently.

Dr. William James, Long Valley, recently took a trip to Pennsylvania to hunt deer.

Dr. Frank L. Bird, Netcong, returned recently from a two weeks' hunting trip in Maine with a fine deer and some small game.

Dr. Henry S. Martland, Newark, has an excellent article in the November Bulletin of the Dept. of Health, on "The Present Status of the Curability of Syphilis."

Dr. Wells P. Eagleton, Newark, addressed the Chicago Neurological and Otolological Society on the evening of December 2nd.

Dr. John J. Brozdowski, Jersey City, has moved his office to 554½ Jersey avenue.

Dr. Louis A. Pyle, Jersey City, and wife recently welcomed to their home a little baby daughter.

Dr. Hugh H. Tyndall, Weehawken, and wife welcomed another daughter in their home.

Drs. J. Morgan Dix, Metuchen, is taking a special course in the eye, ear, nose and throat department of the N. Y. Polyclinic.

D. Archibald Mercer, Newark, has been confined to his house by illness.

Dr. Lester Foye Meloney, Clifton, has been bequeathed by Mrs. Kate A. Gelling, Passaic, one-seventh of her estate, "in appreciation of his devoted attention to my brother in his last illness."

Journal of The Medical Society of New Jersey

Published on
the First Day of Every Month



Under the Direction
of the Committee on Publication

Vol. XXI, No. 2

ORANGE, N. J., FEB., 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

THE UNDERNOURISHED OR SUB-NORMAL CHILD*

By **Sydney Chayes, M.D.,**
Bayonne, N. J.

The undernourished child has become a dramatic national figure, awakening country-wide interest in a new standard of child health. In many towns and rural districts a feeding experiment for an undernourished group has resulted in a hot lunch for the whole school. As simple an undertaking as a weighing contest has aroused a school board to undertake the keeping of weight records in the schools, and the teaching of health habits. Nutritional classes conducted in clinics and in schools have inspired hundreds of teachers to give to all children this new gospel of child health.

Malnutrition is a condition of undernourishment or underweight; it is an important condition and one which is often neglected, for it may lay the foundation for poor physical development or ill health in adult life. Children suffering from malnutrition are not only very much below normal weight for height, but they gain much more slowly than they should. They do not all behave the same way; some are pale, dull, listless, are easily tired, and have no ambition, while others are nervous and fretful, overambitious, and cannot concentrate.

Malnutrition is due to insufficient food, improper food, irregular eating of indigestible food between meals, bolting of food, lack of sleep, habitual constipation, too much stimulation and emotional excitement, too intense play or overwork, in school or out, or constitutional diseases; it is aggravated by decayed teeth,

enlarged tonsils or adenoids. It may cause the individual to grow up undersized and underweight, and unable to do the work of a man or woman. The commonness of the condition is shown in the selective draft where one out of four of the young men examined was rejected, forty thousand being found unfit because of developmental defects.

This undernourished condition is cured by correcting the habits or removing the causes upon which it depends. In infancy the diet should consist wholly of milk, with the addition of orange or prune juice for bottle fed ones; as they grow up cereals, vegetables, cooked fruit, etc. are added. In the diet for older children, food supplies the materials essential for growth, and is the source of body heat and energy. It should contain fat, carbohydrates, proteins, salts, water and vitamins. The best index of growth is age to height. If the height is not up to the age, then it may be assumed that food accessory substances are deficient; if the weight is too low for the height, one may look for a deficiency in the caloric intake.

All unfavorable hygienic conditions, lack of proper food particularly bear most heavily upon children because they have less resistance than adults and are more susceptible to infection. Their food allowance must be not only sufficient for energy and the repair waste, but in addition a large allowance must be supplied for growth. Furthermore, there are certain food constituents essential for growth, and unless these are furnished in the food, growth suffers, even though the quantity of food is sufficient. The health, growth, and physical development of children, and to a large extent their mental development and progress depends upon their nutrition.

The physician takes a great deal of

*Read before the Bayonne Medical Society, January, 15, 1923.

time with and displays immense interest in the feeding of the infant whose mother has not sufficient milk to feed it; he advises certain formulas, and milk or dry foods, and so juggles them until the child thrives. Just as soon as these children or breast-fed ones reach the age of one or two years, he seems to lose control over them, either because of lack of interest by the mother or because the doctor thinks he has done his bit in helping until the child is old enough to take a more liberal diet. It may be that the mother thinks she no longer requires the advice of her physician, because the child is no longer restricted to milk. But the fact remains that we no longer give a helping hand to the child at the age when it is building its foundation for later years, and the time when it is most needed, for a good start, most usually, means good progress and a sound body.

An effort must be made by the physician to enlighten the parent what and how to feed her growing children. I believe the average man thinks that the mother knows what food to give the child, or else he has not the time to sit down for a few minutes and talk to the average willing but unknowing mother, many of whom do not even know how to properly prepare food. They must be taught to place food before the children in such a manner as to tempt and not disgust them. The doctor should be kind and gentle to the child, and try to gain his friendly feeling and confidence, but not his fear, for a great deal can be accomplished by kind words and a gentle pat on the back. Once you gain their faith, it is really surprising how much you can get a child to do for you, in fact, at times more than the mother can accomplish, for it is the human instinct in the child to try and please. But once the child fears and dislikes you it is a difficult task to get results. So let us remember to be kind, gentle and patient with mothers and children, for in so doing we can accomplish great good.

The trouble with most parents is that they do not know what food to give the children, that they might get the proper constituents necessary for growth and repair. The average physician does not take the time to explain to these mothers, with the result that the child suffers. These two factors are the main causes for the undernourished child and a great deal of ill health among children. If you

sit back and think of the children you have attended or are attending at the present time for most of the contagious diseases and other ailments, you will find that most of them are undernourished and hence less resistant to disease than those up to weight. They have not the power to combat the infection and ward it off, or they have not the ability to make anti-toxin, as it were, and kill the germ as the child who is up to weight. Just because we say that Scarlet Fever, Diphtheria, Measles, Whooping Cough, etc. are children's diseases, it does not mean that all children must develop them. But, if the child is undernourished and hence less resistant to disease, the cause of these diseases makes a harvest on these poor unfortunate ones, because they meet with little opposition; the child cannot combat the toxin and hence succumbs to the disease. It will be noticed that most of those who do not develop these conditions are those who are up to weight.

It is up to the physician in private practice to keep the people well and lower the death rate or else the state will take a hand and appoint salaried physicians for that purpose. Remember that if we are not careful, the time will not be far off when we shall have State Medicine in the United States. In fact, we have State Medicine now and yet we do not fully realize it. Look at our city, county, and state hospitals, our free clinics in the hospitals, the physician in the schools, the county clinics, the nutrition classes, etc. The city and the state have begun to take a hand in treating and teaching the people how to take care of themselves. Look at all the medical propaganda sent out in pamphlets, and lectures to citizens. If we do not take it upon ourselves to teach our patients how to be healthy and fully nourished, then the state will, for it realizes that in order to have men and women capable of helping instead of hindering progress, all efforts must be bent towards giving good foundations to the children that they might grow up to be sturdy and resistant, because the recent war has shown the effects of lack of proper food on the unfortunate children of Russia, Poland, etc. It is therefore up to us to instruct mothers and emphasize the importance of proper food, rest, etc.

That the undernourished child can be

made to gain weight, let me cite the record of two classes of the fresh air school. The routine weighing takes place on the 27th of each month. During the period from September 27 to October 27 one class of twenty-five pupils gained sixty-five pounds, whereas, the normal gain for that period was nineteen pounds. This means that instead of each pupil gaining the required three-quarters of a pound, each gained on an average of two and three-fifths pounds, or more than three times the normal gain for one month. It was indeed very encouraging to notice that several of these children gained over five pounds, in fact one gained seven pounds. Another class of nineteen pupils during the same period gained thirty-five pounds, as compared to the required gain of nine and one-half pounds. In other words, instead of each pupil gaining half a pound, each gained one and three-quarter pounds, or three and one-half times the normal gain. In this class several children gained five pounds, one in particular, gaining six pounds, which is the weight each child should take on in one year. During the second month of school these children gained about twice the normal gain. As these children come up to the standard weight for their height it is noticed that their gain is not as large as when they are undernourished.

The routine of our work is as follows: A complete physical examination of each pupil in the presence of the parent or relative, no child is examined unless either is present. If any defects are found these are pointed out to the parent, and the remedy insisted upon. The teacher and nurse follow up these recommendations, and hence the cause for the undernourished child is removed, with the resulting gain in weight, height, strength and mental capacity. Individual talks are given to the parents with regard to diet, rest, fresh air, recreation and sleep. Each mother airs her complaints about her child and advice accordingly given. We always insist on the mother being the boss, instead of the child. Frequent talks are given to the children, and their confidence gained. As we try to instill friendly rivalry among them, it is interesting to note the earnestness displayed in the game, and the discouraged look on the face of the child who does not gain as rapidly as the other, the result being that the former soon makes up for the past.

The importance of different kinds of food is impressed upon the mother and the child. As the child of today is the adult of tomorrow, so the kind of food a child has today, determines to a considerable extent the fitness of the future citizen. Hence those who direct the feeding of the child have a responsibility which cannot be overlooked. Good food habit should start today, for tomorrow may be too late. The very first impression we try to make is that the children have their meals the same hours every day. However, if the child gets hungry two hours before the next meal, he may be given a slice of bread, or a glass of milk but not candy, cake, fruit, nuts, or cookies, for these latter ones rob the child of his appetite for the next meal. The mother is advised to keep her child at the table at least twenty minutes, for it is a known fact that children bolt their food without much mastication that they might go out and play. Within a short time, the youngster realizes that he must sit down for a time, and hence eats more slowly, thereby chewing his food properly. Children should drink plenty of water between meals; water will often satisfy the craving which many mistake for hunger. It is very important that children be taught to eat things which are beneficial to them; the mother should be patient but firm, in teaching a child to like new food; she should begin by giving a small amount at first and then increase it; one new food should be given at a time, and repeated regularly until the youngster learns to like it.

Many mothers in their anxiety and interest that their children might gain, often force them to eat when they are not hungry, a mistake which should be carefully avoided, for forced feeding does more harm than light eating for a few days. If however, the child's appetite does not return, the advice of a physician should be sought. A child should not be allowed to make his entire meal from one or two articles, as he needs a variety of food to supply all kinds of growing material. We all know that milk is the most important and necessary food for the growing child, and that it should be taken slowly and warm, for in this manner it is most easily digested, being a food and not a thirst quencher. We often find that a child rebels against milk, but this should not prevent him from getting any, for it can be given in the form of cus-

tards, cocoa, or milk soups. Tea and coffee should not be given to growing children at all. The child should be given eggs, fish, fowl, fruits, vegetables, cereals, bread, and the dairy products. Personally I do not believe it best for the growing child to eat meat, for it is noticed in families where meat is served often that the youngster will make his whole meal from it and eat very little of anything else. For some reason, or other, the child is fond of it, and will take as much of it as is given, and not eat any other food, and for that reason alone I do not advise it with the exception that a small amount of lamb may be had at times. Vegetables and fruits are excellent sources of iron and other elements necessary for growth, which, combined with milk, supply food value more than equal to meat. Bread, cooked cereals and other grain products should constitute about one third of the food required by the child; the food value of cereals can be increased by the addition of dried fruits, as dates, figs, and stewed prunes. It is important that they should be thoroughly cooked and properly served, for if not, the child will often refuse to eat them. The vegetables form an essential part of the diet, and they are very important in helping to guard against constipation, a frequent cause for the child's lack of appetite and vim. Potatoes, either baked, boiled or mashed should be given every day; other valuable vegetables are dried and fresh peas, beans, spinach, tomatoes, onions, string beans, carrots, turnips, squash, cauliflower, asparagus, and celery. Whenever possible fresh vegetables should be served in place of the canned. Fruit either fresh or dried, but fresh preferably, should be in the diet every day. There is a great danger of children getting too much sugar, thereby spoiling the appetite and digestion; however, it is less likely to be harmful when taken in cocoa, puddings, custards and vegetables. When sweets are given it is advisable to leave them for the last part of the meal, and not at the beginning, for they spoil the appetite for the necessary food. The necessary fat is supplied in the butter, cream and oil, but food freed of fat should be carefully avoided.

Being in a position to see the physical condition of children in the schools, it is alarming to notice the large number who show one or more physical defects. It is estimated that seventy-five per cent. or

sixteen million school children in the U. S. are suffering from one or more physical defects, most of which can be remedied and yet are not. The school doctor reports to the nurse that the child needs dental care, glasses, or the removal of T & A, these three being the chief physical defects; the nurse reports back to the family the defects and their remedy, but that is all that happens. The parents pay little heed to these warnings, and yet the poor child suffers. Now, if the average physician insisted on remedies whenever he went to his families, a great deal of good could be accomplished, because the parents look up to their doctor. If they cannot pay for the work they should then advise hospitalization, for relief must be had. It is estimated that one per cent., or 200,000 of the twenty million school children in the U. S. are mentally defective; over one per cent., or 250,000 are handicapped by organic heart disease; at least five per cent. or 1,000,000 children, have now or have had tuberculosis of glands, bones or lungs; five per cent. or 1,000,000 have defective hearing, which unrecognized, gives many the undeserved reputation of being mentally defective; twenty-five per cent of 5,000,000 have defective eyes, all but a small percentage of these can be corrected, and yet a majority of them have received no attention; fifteen to twenty-five per cent., or to five million have adenoids, diseased or hypertrophied tonsils or other glandular defects; from ten to twenty per cent., or two to four million have weak foot arches, weak spines, or other joint defects; from fifty to seventy-five per cent., or from eleven to sixteen million of our school children have defective teeth, and all defective teeth are more or less injurious to health; seventy-five per cent., or sixteen million of the school children in the United States have physical defects which are potentially or actually detrimental to health, and yet most of these defects can be remedied. So you see, gentlemen, from the above statistics, the important work before us who go into the families as advisers; if we will but only take a little time, and carefully examine the child for defects, and advise relief, I am sure our mortality rate will be materially reduced, as well as the morbidity.

It is estimated by the best authorities that three out of every four children in this country are suffering from some

physical defect which might be prevented or corrected. This means that there are perhaps fifteen million such school children in the country today. From one cause or another every member of this great group of children is suffering not merely from one, but from many physical defects. They constitute the class of mal-nourished children whose great number is a shame to our civilization. These same children, who do not measure up to the standard and remain so, become in later years the men and women who do not measure up—the men who are physically unfit to bear arms in their country's need, and the women who are physically unfit to become the mother of men. It is these men and women, whose offspring, and they are very numerous, are below normal, the ones we are trying to prevent. Health and good habits must be taught to children at the age when they are forming habits for the future, for it is just as easy to master the good and beneficial as the bad, and also remember it is a difficult thing to teach an old dog new tricks.

Our cry is not only to make the sub-normal normal, but to keep the normal child normal; not only to make the sick well, but to keep the healthy healthy. Conserve and preserve health. Our aim is not only to get the undernourished up to weight and strength but to keep the normal child so, for it is most usually the child below par who is always needing medical attention for all contagious and current diseases. Just as the good builder makes a solid foundation for his building, just as the experienced farmer cares for his soil that it might give the best fruits and vegetables, so must we care for our children who are the foundation on which our country rests.

The recent draft has shown how shamefully and pitifully our boys are physically built; a condition that can and must be immensely changed. Just as the sapling that grows out of line can be straightened and supported to eventually be sturdy and strong, so can we, with proper guidance and advice help the young child who is physically subnormal. He is soft and pliable, and can be properly moulded, but if we wait until he has matured and settled, then it is very difficult to mould him. Go to the child early for then is the best time to work and obtain the brilliant results that follow in the future.

A RESUME OF OBSERVATION IN BLOOD TRANSFUSION.*

By Martin Lewis Janes, M.D.,

Instructor of Surgery, New York Post-Graduate Medical School and Hospital.
New York.

With the birth of thought and reason in men, came the observation that the blood contained the very essence of life itself. Primitive man knew its essential importance for the existence of all forms of animal life, but he did not understand the nature of its composition and action and, consequently, it was enshrouded in superstition and mystery. The Bible considers the blood the seat of the soul.

The ancient Egyptians knew the therapeutic value of blood transfusion and it is known that they practiced it. There is a report² of a blood transfusion performed on Pope Innocent VIII. in 1492. Jean Baptiste Denys of Montepellier, physician to Louis XIV., reported³ successful experiments with blood transfusion performed on human beings, using calves and lambs as donors.

Contemporaneously with Denys in France, Lower in England reported³ the transfusion of blood in animals from one species into another. His reports include an interesting transfusion from a "young dog into the veins of an old, which, two hours after did leap and frisk; whereas he was almost blind with age and could hardly stir before." It is interesting to note that he performed an apparently successful transfusion of about 9 or 10 ounces from the artery of a sheep into a man's vein.

Blood transfusion in the nineteenth century met with varying periods of favor and disrepute. During the last half of the nineteenth century experiments were being carried on by Leisrink, Eulenberg and Landois in Germany. In 1884, William S. Halsted reported⁴ several cases of carbon monoxide poisoning treated by what he called refusion of the blood. The blood was first withdrawn, defibrinated, and then returned to the circulation of the patient.

Von Ziemssen's report⁵ on the use of whole blood subcutaneously stimulated further interest in blood therapy. That pro-

*From the Surgical Service of Dr. Charles Gordon Heyd, N. Y. Post-Graduate Medical School and Hospital.

*Read before the Clinical Society of the New York Post-Graduate Medical School and Hospital, March 16, 1923. Read before the Eastern Medical Society of the City of New York, May 11, 1923.

cedure was necessarily accomplished by a good deal of pain, since he used as much as 450 c. c. at a time. He later devised the syringe method, in which a needle was inserted into the vein of the donor and a syringe full of blood was withdrawn and injected through a needle which had already been inserted into the vein of the recipient.

Modern Methods.—The work of Crile⁵ who devised a cannula, was a great progressive stride toward the practical application of blood transfusion. Crile's cannula was later improved by Elsberg⁷. Sauerbruch⁸ and Hartwell⁹ later devised methods of inserting the end of the artery into that of the vein. More or less similar methods were employed by Levin,¹⁰ Janeway¹¹ and others. It was impossible, by these procedures, to determine the amount of blood transfused, except, perhaps, by a method suggested by Libman and Ottenberg¹².

Then followed the method of Brewer and Legget¹³, who used glass tubes coated with paraffin, extending from the donor's vessel to that of the recipient. This method was later modified by Pope¹⁴ who used rubber tubing and Bernheim¹⁵ who used the silver cannula. Curtiss and Davis¹⁶ first received the blood in paraffin coated receptacles to prevent clotting and then injected it into the patient. Later, Kimpton and Brown¹⁷, Satterlee and Hooker¹⁸ and Percy¹⁹ devised methods for measuring the blood and then injecting it. Lindeman,²⁰ in 1914, reported a perfection of the syringe and cannula method, in which more syringes and improved needles were used.

The attention of some investigators was then turned toward the possibility of preventing clotting by means of chemicals. Early in 1915, Hustin²¹ of Brussels and later Weil²² and Lewisohn²³ of this country, each published their experience with sodium citrate as an anticoagulant. Herudin has also been used for that purpose, notably by John Abel, who did a large amount of work with it.

That the transfusion of whole, unmodified blood is superior in value to blood adulterated by an anticoagulant, has been proven by various investigators, notably Novy and De Kruif²⁴, Drinker and Brittingham²⁵, Clowes²⁶ and Unger.²⁷ They have shown conclusively that sodium citrate causes some changes in the blood platelets which is responsible, to a degree, for the chills which follow the citrate method. That sodium citrate renders the red blood cells more fragile and diminishes the available quantity

of compliment. That the presence of sodium citrate in the blood reduces the function of the opsonins and destroys the phagocytic power of the white blood cells. It also has a tendency to sensitize the patient to subsequent transfusions.

Clowes²⁶ has pointed out the similarity of sodium citrate and sodium chloride as to their general toxic effect upon protoplasm. The late Dr. Lindeman, in a report²⁸ of two hundred and fourteen consecutive cases without a chill, accounted for his brilliant results by the use of pure, unmodified blood, introducing no foreign material, not even physiological salt solution, into the circulation of his patients.

Without any doubt, the syringe method is the greatest advance that has thus far been made in surmounting the mechanical difficulties encountered in blood transfusion. In recent years numerous devices have appeared in which the syringe is the agent used in transplanting the blood.

Obviously, an ideal apparatus for direct blood transfusion is one which provides a continuous flow of blood from donor to recipient, thus eliminating the possibility of clotting during the course of transfusion, without the necessity of introducing sodium chloride solution into the blood of the recipient. It is with this idea in mind, that I began, some years ago, experimentations in which two syringes were used, one filling from the donor while the other was discharging into the recipient and vice versa. An apparatus was perfected which was presented before the Surgical Section of the New York Academy of Medicine and a description of which was later published.²⁹ It provides an uninterrupted flow of blood from donor to recipient, requires only one man to operate it, and reduces the length of time necessary for the transfusion, two syringes being in constant operation instead of one. No saline solution is necessary to prevent clotting.

Sera-Immunological Aspects.—If it were the mechanical difficulties alone that confronted the procedure of blood transfusion, its status in our therapeutic armamentarium today would indeed, be a different one. It was because of accidents, frequently disastrous, the nature of which was little understood, that the procedure met with periods of condemnation and discredit.

Landois³⁰ first showed that the serum of one animal may have the property of destroying the red blood corpuscles in another. Haymen³¹ later reported that a transfusion

from an ox to a dog caused a serious reaction, resembling purpura hemorrhagic, which resulted in death in a few hours.

It was not until the observation made by Landsteiner³² in 1900, that when the serum of a certain species was mixed with cells of certain other members of the same species, clumping or iso-agglutination occurred, that some light began to be shed upon the cause of severe post-transfusion reactions. In his study of the inter-reactions of sera and corpuscles, he found in phenomenon normal to man, and accordingly classified all human beings into three groups.

Jansky,³² and later, Moss³⁴ showed that individuals could be divided into four groups according to the inter-agglutination of their bloods. Unfortunately, Moss employed a system of numbering of the groups the opposite to that of Jansky, which gives rise to confusion unless the systems are named. Iso-hemagglutinins have been extensively studied by also, Gay, Brem, Kextoen, Ottenberg and others. The groups are not present at birth but become established at about the end of the fourth year of life and are heritable according to the Mendelian Law.

In order to explain the existence of the groups, the theory has been put forth that the serum contains agglutinins and that the cells contain receptors for these agglutinins. Moss believes there are three distinct agglutinins, one for each of the agglutinating serum II., and III. IV. According to Von Dongern and Hirschfeld³⁵ there are only two agglutinins, one in group II. serum and one in group III. and both of these in group IV.

The group relationship prevails in both agglutination and hemolysis, that is, if a serum shows iso-hemolytic properties, it is also iso-hemagglutinative. The converse does not hold, namely, that if a blood contains iso-agglutinin it does not necessarily mean that it will similarly dissolve red corpuscles.

Selection of Donor.—This particular method used for transplanting the blood dwindles into insignificance, as far as the safety and welfare of the patient is concerned, as compared with the importance of properly grouping and testing the blood of the patient against that of the donor. The practical application of the grouping of individuals according to their iso-agglutinin reaction and the simplification of technique have rendered blood transfusion safe. The procedure, however, is fraught with dan-

ger when practiced by one whose eye and judgment is not trained for the correct performance and interpretation of the preliminary tests. Several unpleasant post-transfusions reactions have taught me not to rely upon the report of laboratory technicians. I have since never attempted a transfusion without personally performing the blood tests.

The prospective donor should undergo a thorough physical examination. His Wassermann should be negative. His hemoglobin, red and white blood count should be normal. The common practice of determining the "group" of the patient and transfusing the blood of a donor of the same "group" should be discouraged. I have seen severe reactions following that procedure, although the blood of the donor was of the same group as that of the recipient. The reactions has been explained by the presence of "minor" agglutinins in the blood in addition to the "chief" or "major" agglutinin. To eliminate these reactions, in addition to determining of groups, the blood of every prospective donor should be tested directly against the patient's blood. Occasionally, an incompatibility exists between the blood of a mother and her new-born infant and it is therefore unsafe to perform a transfusion from mother to child without the preliminary direct tests.

Therapeutic Value.—The value of blood transfusion as an efficient therapeutic procedure has been firmly established. It has been used in the following conditions; melena neonatorum, hemophilia, pernicious anemia, illuminating gas poisoning, hemorrhage, endocarditis, typhoid fever, dysentery, secondary anemias, shock, leukemias, intoxications, septicemia, purpura hemorrhagica, tumors, scarlet fever, pellagra, malnutrition, general debility, exophthalmic goitre, tuberculosis and for vaccinating purpose.

Space will not permit a detailed discussion of the relative merits of blood transfusion in all of the conditions enumerated above, suffice it to state that repeated blood transfusions, as a life-saving measure and in combating disease, have produced brilliant results. It is a specific in melena neonatorum. Excellent results have been obtained in hemophilia and in hemorrhage. In the latter it acts not only to replace the lost blood but also actually checks bleeding. It is of distinct benefit in typhoid fever, when donors who have recently recovered from

that disease or who have been vaccinated against it are used. The use of vaccinated donors opens a field of tremendous possibilities.

SUMMARY.

1. Blood transfusion has been recognized as an effective therapeutic measure and practiced since time immemorial.

2. The procedure should be attempted only by those who are skilled not only in the technique of transplanting the blood but also in performing and interpreting the preliminary blood tests.

3. For the best results, no material alien to the blood, not even physiologic salt solution should be introduced into the blood of the patient.

4. The utmost care should be used in the selection of donors. The blood of all prospective donors and recipients should not only be grouped but also tested directly against each other.

BIBLIOGRAPHY.

1. Leviticus, XII., II.
2. Villari: *Life of Savonarola*.
3. Lowthrop, John: *Philosophical Transactions and Collections of Medical and Philological Papers*, London, 1731.
4. Halsted, William S.: *Refusion in the Treatment of Carbonic Oxide Poisoning*, *Ann. of Anat. and Surg.*, January, 1884.
5. Ziemssen, von: *Ueber die Subcutane Blutinjection und uber eine einfache Methode der intravenosen Transfusion*, *Munch Med. Wehnschr.*, 1892, Nr. 19, p. 323.
6. Crile: *Hemorrhage and Transfusion*, (Apleton) 1909.
7. Elsborg, Charles A.: *A Simple Cannula for the Direct Transfusion of Blood*. *J. Am. M. Asso.*, March 13, 1909.
8. Sauerbruch: *Munch Med. Wehnschr.*, 1915, LXII., Nr. 45.
9. Hartwell, John A.: *A Simple Method of Blood Transfusion with Cannula*, *J. Am. M. Asso.*, Jan. 23, 1909.
10. Levin, Isaac: *Plastic Surgery of Blood Vessels and Direct Transfusion of Blood*, *N. Y. Ann. of Surgery*, May, 1913.
11. Janeway, Henry H.: *An improved Device for Transfusion*, *Ann. Surg.* LXIII., 1911, 720.
12. Libman, E. and Ottenberg, R.: *A practical Method of Determining the Amount of Blood Passing Over During Direct Transfusion*, *J. Am. M. Asso.*, Mar. 7, 1914.
13. Brewer, George E. and Leggett, Noel B.: *Direct Blood Transfusion by Means of Paraffin Coated Glass Tubes*, *Surg. Gynec. and Obst.*, September, 1909.
14. Pope, Laxton: *Simplified Transfusion*, *J. Am. M. Asso.*, April 26, 1913.
15. Bernheim, Bertram M.: *J. Am. M. Asso.*, April 6, 1912, 1007.
16. Curtiss, A. H. and David V. C.: *Transfusion of Blood by a New Method Allowing Accurate Measurements*, *J. Am. M. Asso.*, Jan. 7, 1911, p. 1453.
17. Kimpton, A. R. and Brown J. Howard: *A New and Simple Method of Trans-*

fusion, *J. Am. M. Asso.*, July 12, 1913.

18. Satterle and Hooker: *The Further Development of an Apparatus for the Transfusion of Blood*, *Surg. Gynec. and Obst.*, 1914, XIX., 235.

19. Percy, N. M.: *A Simplified Method of Blood Transfusion with a Report of Six Cases of Pernicious Anemia Treated by Massive Blood Transfusion and Splenectomy*, *Surg. Gynec. and Obst.*, 1915, XXL., 360.

20. Lindeman, Edward: *Blood Transfusion by the Syringe and Cannula System*, *J. Am. M. Asso.*, 1914, LXIII., 1542.

21. Hustin: *Ann. et Bull. Soc. Med. et Nat.*, Bruxelles, 1914, No. 4, 104.

22. Weil, Richard J.: *Sodium Citrate in the Transfusion of Blood*, *J. Am. M. Asso.*, Jan. 30, 1915, p. 425.

23. Lewisohn: *Med. Record*, Jan. 23, 1915. *Surg. Gynec. and Obst.*, 1915, XXXI., No. 1.

24. Novy, F. G. and DeKruif, P. H.: *Anaphylaxis*, *J. Am. M. Asso.*, 1914, May 26, 1917.

25. Drinker, C. K. and Brittingham, A. H.: *Transfusion Reactions*, *Arch. Int. Med.*, 23, 133 (Feb.), 1919.

26. Clowes, G. H. A.: *J. Phys. Chem.*, 20, 407, 1916.

27. Unger, L. J.: *Deleterious Effect of Sodium Citrate Employed in Blood Transfusion*, 77 p. 2107, (Dec. 21,) 1921.

28. Lindeman, Edward: *J. Am. M. Asso.*, 72, p. 1665, (June 7), 1919.

29. Janes, M. L.: *A New Combined Blood Transfusion and Aspirating Machine*, *J. Am. M. Asso.*, 75, p. 241, (July 24), 1920.

30. Landois, Leonard: *Die Transfusion des Blutes*, Leipzig, 1875.

31. Hayem: *De la Transfusion du Sang*, 1882.

32. Landsteiner, K.: *Centralbl. f. Bakteriologie*, Part 1, 27, 357, 1900. *Wien. klin. Wehnschr.*, 14, 1132, 1901.

33. Jansky, J.: *Sborn. klin.*, 8.85, 1906-1907.

34. Moss, W. L.: *Bull. Johns Hopkins Hosp.*, 21:63, 1910, 22:238, 1911.

35. Von Dungern, E., and Hirschfeld, L.: *Ztschr. f. Immunitätsforschung*, Orig. 4:531, 1909-1910; 6:284, 1910; 8:526, 1910-1911. 166 West 72nd Street.

THE IMPORTANCE OF THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS AND THE PHYSICAL SIGNS BY WHICH SUCH DIAGNOSIS IS MOST READILY OBTAINED.*

By Warren H. Fairbanks, M.D.,

Medical Director of the County Tuberculosis Hospital at Allenwood, N. J.

Freehold, N. J.

It was my privilege to be a member of the Board of Manager of our County Tuberculosis Hospital at Allenwood from its inception. As a member of that board, I entered upon its work without any special interest in tuberculosis other than that of

*Presented before the Monmouth County Medical Society, Wednesday, November 28th, 1923.

any general practitioner in any of the so-called constitutional diseases. Being thrown into more or less intimate relation with this work and those engaged in it, I naturally came to possess a greater enthusiasm and interest in the fight which is being carried on against this disease.

I wish to impress upon you tonight the very great importance of making an early diagnosis of Pulmonary Tuberculosis when it exists in our patients. At the very outset allow me to state that this paper is plageristic throughout. In many instances I know where I got the ideas, and in many others I do not recall. Suffice it to say that there is very little originality in the present day, and when any man gets an original idea, he usually gets a Ph.D. soon after.

Tuberculosis has ever been one of the greatest scourges to menace humanity. When Koch announced his great discovery in 1882, what rejoicing there was amongst the ranks of those fighting this dread disease. "Now that we have the germ" they said "we certainly can find a cure for the disease itself." And yet after 41 years we are today, so far as a specific cure is concerned, no nearer success than when Koch discovered the Tubercle Bacillus. Right at this point, however, there are some things that we should remember. Tuberculosis is not the menace today that it was fifty or one hundred years ago. During the last century there has been in all countries a constant decline in the death rate. This has occurred with few exceptions, a marked instance of which was the sharp rise during and after the Great War. It is encouraging to know that the man today who finds himself a victim of active tubercular infection stands a far greater chance of recovering his health than had he lived fifty or one hundred years earlier. This is true for many reasons: Improved living and working conditions, better social environment, together with a greater knowledge of the infection from, and the resistance of the individual, to the disease. Added to this is the splendid results arising from the work done by numerous sanatoria, especially their teaching tubercular people how to care for themselves and at the same time protect their families and the public from infection.

How are we then today as the average general practitioners of medicine to meet this ailment and overcome it? I am going to mention only one method, but that seems to me to be of paramount importance. We

must make an early diagnosis of the disease when it exists in our patients. Of the cases which come to the various centers for treatment a tremendously large number of them are not only moderately advanced, but a great number of them are far advanced cases. This is not by any means altogether the fault of the physician, but it is more often due to the neglect of the patient himself. There must be not only alertness on the part of the physician but an enlightened public as well.

The diagnosis of incipient or to use a better term, minimal tuberculosis, is not difficult although there are difficult cases. To my mind there is no reason why any physician should not be able to detect it even in its early stage. There are cases which defy every means used in physical diagnosis, but they are not so common as to cause discouragement. Dr. Lawrason Brown states that they have cases at Trudeau that exhaust every means for diagnosis and leave them entirely in the dark as to whether the patient has tuberculosis or not. Now, although the early case has its signs which as a rule may be readily found, it does require a careful, persistent and thorough examination of the chest in order to do so. The physician who attempts to examine his patients without asking them to remove their hat and overcoat will still continue to treat early tuberculosis for bronchitis and what not. It is a prerequisite that the patient, male or female, should be stripped to the waist. In the examination all the ancient and classical methods are used, namely, inspection, palpation, percussion and auscultation. Bear in mind that much that I am about to say is true only of the early cases. There are some things which are of little value in the early diagnosis, but are of great value in the more advanced cases.

Inspection.—Of how much value is inspection in the early stage? It certainly should be employed, but in the strictly early case it is my opinion that it is of slight and relative value only. At the New York State Sanatorium at Raybrook last spring during the course at Trudeau, Dr. Garvin of Buffalo, after a very exhaustive lecture upon this subject, had 25 patients lined up in front of the class of 27 physicians. These patients were numbered from one to twenty-five and the physicians were asked to pass in front of them and using inspection alone to state whether they had tuberculosis or not. Each physician jotted down upon a pad the number of the patient, whether

there was disease or not, and whether it was lateral or bilateral if present. The reports were turned in for correction. The class made exactly 675 observations and, although there was great unanimity of opinion, just 3 per cent. of them were correct. When Dr. Garvin read the report he said: 'Cheer up, for that is about what you may expect in the diagnosis of early tuberculosis if you depend on inspection alone.' There is one method which in these early cases seems to me to be of considerable value. If you stand behind the patient and have him tip his head forward you will be able to look down over both shoulders and watch the clavicles and chest beneath expand upon each inspiration. If you observe closely you will often detect inequalities of expansion. A slight lagging of one side is of considerable significance.

2. *Palpation*.—This also is of small value. In the early cases vocal fremitus is normal. However, where we sometimes find upon inspection a lagging of one side as I have just mentioned, if with this we palpate and find a slight rigidity of the muscles of the apical region of that same side then we have somewhat strengthened our case and have a right to suspect trouble beneath.

Percussion.—Upon this point we may all be satisfied for here we have a clear case where "physicians disagree." If you feel that percussion is of no value in incipient tuberculosis you may fortify your argument with that of such illustrious students of the disease as Grancher and our own Lawrason Brown. These men claim that small tuberculous foci in the lung in incipient phthisis can be recognized solely through recourse to auscultation, and that when dullness is elicited upon percussion we are dealing with a more advanced stage of the disease. On the other hand if you are of the persuasion that percussion is of great value you may fall back on the observations of men equally illustrious in this field of endeavor such as Aufrecht, Kronig, Goldscheider, William Ewart and others. These men claim that we must always resort to percussion if we are to detect incipient lesions in phthisis, and that it is only when the process is advanced that we get definite auscultatory signs. You may make your own choice. So far as my own opinion is concerned, having been under Lawrason Brown's instruction for six weeks not long ago, my mind which was perhaps somewhat weak and flexible at this point may have been warped slightly in his direction. How-

ever, I feel that there is a middle ground and no doubt cases could be found illustrative of both contentions. Probably no better group of men, so far as the art of physical diagnosis is concerned, is to be found than that composed of the physicians of Saranac Lake. The method of percussion taught at the Trudeau School is called the elevator dial method. The physician sits directly in front of the patient. The palm of the left hand is placed at the base of the sternum, and, using the palm as a pivot, the hand is rotated from side to side always placing the finger used as a pleximeter in corresponding interspaces. The percussion, as indicated, proceeds from below upward since it is easier to detect a slight dullness when approaching it from an area of normal resonance. Using only wrist motion the percussion stroke should be very light since you are aiming to detect small areas of dullness and a heavy stroke would set in vibrations surrounding areas of normal lung tissue and completely obscure the small foci of disease which might lie directly under the point of percussion. The only way to tell a very slightly dull note is by the pitch which will be slightly higher in tone than that of the normal vesicular resonance.

4. *Auscultation*.—Here without question it seems to me that we have our most valuable means of making an early diagnosis. Before we are able to make any decision as to abnormal conditions we must know the human chest with absolute verity under normal conditions. This is not difficult, but if we do not know these simple facts about to be mentioned we will always have difficulty in making an early diagnosis of phthisis. There are three types of breathing heard in the normal chest, bronchial, broncho-vesicular and vesicular. Bronchial breathing is heard normally in an exaggerated form over the trachea. The best place is over the 7th cervical vertebra. (If you wish to hear it as a matter of comparison you will in nearly every individual get a beautiful illustration of it over the temporal region.) Vesicular breathing is heard over the entire chest with the following exceptions: Anteriorly on the right the breathing is slightly broncho-vesicular to about the 2nd rib. The same is true posteriorly on the right to about the 5th V. S., and there is usually a small area of this sort just to the right of the scapula on the left side. We should first auscultate for these breath sounds and any irregularity should be noted.

Now we come to what is of unrivaled value in the diagnosis of pulmonary phthisis in almost any stage of the disease—the rale. Rales have always troubled me. There were dry and there were moist and I could never recall the one from the other. Thank the Lord at Trudeau they have nothing but moist rales. Their conception of the rale is very simple and very easily remembered. They admit that some rales have a dry sound but they maintain that as long as they are caused by some degree of moisture therefore they are moist. The classification of rales is as follows:

1. *The Crepitant Rale*.—This rale is almost never heard in tuberculosis. We are all familiar with this rale. It is the one heard in the beginning of lobar pneumonia and occurs in showers at the end of inspiration. Dr. Lawrason Brown states that he has heard the crepitant rale in only a few cases of tuberculosis. I have noticed that many writers, including Fishberg, speak of the crepitant rale, but I think what they refer to is the subcrepitant rale under the old terminology. This is the rale redux, the one heard during the resolution of a lobar pneumonia.

2. *Fine Rale*.—This is the same as the subcrepitant or the rale described by Austin Flint as the fine bubbling rale. This rale is heard very often in tuberculosis, and usually throughout inspiration.

3. *The Moderately Coarse Rale*.—This is slightly coarser than the fine rale and is the rale which is probably most often encountered in tuberculosis. It is heard in any phase of respiration and is more moist and lower pitched than the fine or crepitant rale which are both high pitched.

4. *The Coarse Rale*.—This is still lower in pitch and more moist. It occurs in any phase of respiration and originates in the larger bronchi.

5. *The Cavernous Rale*.—This may be either high or low in pitch and resembles the sound of boiling liquid in a flask or test tube. This is only of value in the advanced stages of the disease.

6. *Ronchi*.—These are widely transmitted and may become altered or disappear during examination. The sonorous are low pitched and the sibilant are high pitched.

The moderately coarse rale, as stated above, is the one most frequently heard, and is heard very often in early cases. Very often these rales are not elicited at all when the patient merely breathes quietly as you listen with the stethoscope. You may heard

only what seems to be perfectly normal breathing and still you may be listening directly over an area of disease. Now in these cases if you will have the patient at the end of each full expiration give a slight cough you will often bring out these latent rales in large numbers. The rale is the thing of importance and we should become thoroughly acquainted with them. Rales which persist in an apex are almost always pathognomonic of tuberculosis.

REFERENCES:

- Pulmonary Tuberculosis by Fishberg.
- Physical Diagnosis by Austin Flint.
- The American Review of Tuberculosis.
- Notes taken by the writer during the course at The Trudeau School for the Study of Tuberculosis.

THE NEURASTHENIC ABDOMEN.

By Wm. Edgar Darnall, M.D., F.A.C.S.
Atlantic City, N. J.

So much is said nowadays about the "acute abdomen" which is always a surgical emergency and sometimes a tragic one, that it is well to pause and consider the more common condition of what we may term the "chronic abdomen." If the acute abdomen, as has been said, is a catastrophe, the chronic abdomen is a conundrum and needs most careful and painstaking study to unravel. There is probably no physician actively engaged in his profession that does not at all times have one or more cases of chronic abdomen among his clientele.

The symptoms of the chronic abdomen are many and varied and often renewed. The subject is usually a woman, generally a spinster or childless married woman. The abdominal man is a rare bird and when caught most often turns out to be either a neurotic or a doctor. The sufferers from chronic abdomen are very fond of presenting in great prolixity, to anyone who will listen, a full record of their ailments and an accurate pedigree of all their experiences. Pains and aches are referred to all points of the abdominal compass, but especially to the right iliac region, the pelvis, the stomach and gall bladder region. There are dragging sensations, peculiar raw feelings of the insides nearly always constipation, flatulence, weakness and exhaustion, headaches, neuralgias, catarrhs, etc.

However, it is not all imagination as the preceding remarks would seem to indicate. There is a more or less evolutionary basis back of it. These patients usually conform

to a certain type and that is the type of non-development. One can guess at the diagnosis as they walk along the street. They are usually rather tall, thin, flat chested, long narrow waisted. The pelvic organs are of the infantile type and the uterus frequently retroverted. The kidneys float. The colon sags. There is gastropnoxis, and the congenital developmental bands as seen in Jackson's membranes, Lane's kinks and other intestinal bands.

Before the days of our more modern and accurate scientific methods, Glenard classified these cases clinically so well that a general visceroptosis of the contents of the abdominal cavity was given and still bears the name of Glenard's disease.

Richard R. Smith of Grand Rapids some years ago made a most interesting and comprehensive study of hundreds of school children and was able to pick out by their developmental and physical characteristics those who were travelling along the road which would lead to chronic abdomens when they grew up and matured.

It will be observed that the road to the neurasthenic abdomen is marked by operations of a varied nature. We have gone through the period when it was thought that every woman who had a moveable kidney should have it fixed, especially when it was learned, that nearly all child-bearing women had kidneys given to more or less excursions every time the diaphragm moved. We are now emerging from the period when it was considered proper to remove the appendix under a diagnosis of chronic appendicitis every time some one complained of a little tenderness in the right iliac fossa. Chronic appendicitis may be only one factor in the multiform causes of the suffering of these patients.

These patients usually begin by complaining of pain in the right side. There is always to be found some surgeon with a handy knife who warms enthusiastically to the prospect of removing the appendix. Any new treatment always makes these impressionable patients better and if to the psychology of the matter is added rest in bed and a considerable amount of sympathy there is improvement for a time. Then the symptoms all come back. Another surgeon is consulted who makes the diagnosis of adhesions and promptly sets about to relieve them. Following on the heels of this other operations follow. The gall bladder is attacked, the pelvic organs are removed, short circuiting of the intestines, colectomy, even

gastro-enterostomy and other ill-timed operations are undertaken until if the patient has not a chronic abdomen to start with the surgeon has created one for her.

Meantime her physician has not been idle. The patient has been "investigated" by a clinic. She has been x-rayed and provided with a picture book of her belly. Tonsils and teeth have been removed, vaccines given, diets manufactured, electricity indulged in and now the fad is endocrines. She has run the gamut of all that is known to modern therapy and the only time she is at peace is when her attendant is on a fishing or gunning trip or other form of vacation.

In addition to the physical condition there is the mental aspect which is often most difficult to handle and frequently the most important of the two. General discontent with life, peevishness, hysteria, depression introspection and intense egotism make up the picture and woe to the physician who does not coincide with her as to the utmost importance of her insignificant symptom. The operation habit has strong hold on her for that supplies the spectacular need for the sympathy of her friends and gives her the centre of the stage, while it holds out to her the "Will O' the Wisp of hope." She is willing to undergo all kinds of operations if someone will suggest them to her. She becomes a veritable vampire sucking the vitality of all who come in contact with her. Half an hour with her reduces her doctor to the consistence of a piece of chewed string and is more exhausting than all the duties of a busy day." She knows so much of medicine and doctors that she formulates for herself a new diagnosis every day and expects you to confirm it but she will never stick to anything long enough to get a result from it. Yet she is sick and miserable and needs all the help we can give her.

In the consideration of the general visceroptosis associated with this morbid psychological state we may well ask ourselves the question, how can the physical basis produce all the multiform symptoms complained of by the patient. How much is physical and how much is mental? How much of the mental is caused by the physical? What is the relation of the vegetative nervous system to the emotions and what part do focal infections and auto-intoxication play in the matter? These are questions for grave and serious study.

What can we do to relieve them? In the language of a recent writer, "the most

important thing is to *catch the patient early*, for if once she gets her feet on the slippery slope which leads to repeated and often ill advised operations she is undone."

In my opinion no course of treatment or surgical operation should be undertaken until a thorough and comprehensive study of her case from every angle by physician, surgeon, laboratory, x-ray, and the head specialists, is made. In the milder cases and in the beginning a timely rest cure with the fattening process, the correcting of eye troubles, a properly fitted abdominal supporter that will really support swagging viscera and an understanding physician, who properly appreciates the psychological state may do much to cure the patient.

There is no gainsaying the fact that the severer cases do need surgery but the day would often be saved if all the surgery were done at once instead of subjecting patient to many operations. If the patient of the type described presents herself with varied symptoms and tender abdominal spots let us restrain our first impulse to immediately cut out her appendix. Rather let us insist that she be placed under conditions which the whole anatomy of the abdomen and secretions may be studied and after such a study is completed if surgery is to be undertaken, then the incision should be so placed and be of such size that every organ in the cavity may be thoroughly and systematically investigated. The condition of the gall bladder and stomach, the surrounding adhesions, the duodenum, the kinks about the cecum the Jackson, Lane and Treeves folds and the position and condition of pelvic organs are of far more importance than it is to remove a normal appendix through a two inch incision and have the patient worse off than before. The surgery should be made complete and painstaking as to every morbid detail at this one operation. As a rule there is no one big operation to be done in these cases. Rather it is attention to a number of small reconstructions and repairs. They should be all finished up at the same sitting. Convalescence should not be hurried. Give the patient plenty of time to readjust herself. Then for the future all surgery should be discouraged unless some acute emergency should arise such as an obstruction or other dangerous condition. Certainly colectomy, gastropexy, nephropexy, fixation of the colon and other fad operations have no place here.

These cases we will always have with us and as civilization becomes more complex

they will no doubt increase in number. There is no place in medicine or surgery where good judgment, a level head and an understanding physician is more important than in the early handling of these cases of chronic abdomen, so that the patient may be saved from herself and her over enthusiastic advisers, for after going through five or six surgical seances and an equal number of treatments of a medical or semi-medical nature such a morbid and neurotic mental state is developed that she becomes the despair of the physician, the prey of the faddist quack and the best advertisement of Coueism, Christian Science, Theosophy, Spiritualism and other forms of mental aberration, if she does not indeed sink to that state in which the patient is said to "enjoy" poor health.

ANOREXIA IN EARLY CHILDHOOD

Frederick H. von Hofe, M.D.,

South Orange, N. J.

All physicians who delve in pediatrics know with what frequency mothers complain that their children have poor appetites. It is disturbing to the mother, and indeed to the physician because of the difficulty he experiences in obtaining co-operation in the treatment of these cases.

The patients are usually most frequently slender, very active, and often neurotic type of children. They are sometimes referred to as "wirey type." One or both parents are frequently of the neurotic type. The patient is often the only child in the family, and receives all the mother's or mother's and grandmother's attention.

There are several etiological factors, and usually more than one is responsible in a given case. Faulty feeding should have first place in enumerating the causes. Too much milk is most often responsible. We have heard so much about a quart of milk a day that it is difficult to convince a parent that the child should not have so much. The mother states that the child will take his quart or more of milk each day but refuses all other food; and being disturbed about the condition, and knowing that the child will take milk, the mother pushes the milk intake to the limit. One quart of milk represents about 600 calories. The child in question usually requires about 1,000 calories daily, and one quart or one and one-half quarts of milk daily go a long way in making up the required 1,000. Furthermore, a high milk diet in these children is

likely to cause constipation, and the constipation may play a part in disturbing the patient's appetite.

I believe one of the most common errors in feeding is giving these young children considerable milk over too long a period of time. Children so fed soon become anemic, soft and pasty looking, constipated, and not infrequently develop chronic intestinal indigestion. One pint of milk daily is quite sufficient for the average runabout. Another error is too frequent feeding. There is an erroneous idea that children must be fed in the middle of the morning and afternoon. A cup of milk and crackers or some other food is just sufficient to disturb the appetite for the next meal.

The diet should be a balanced one. Too much carbohydrate, particularly sugars, are prone to disturb the appetite. If the patient selects only certain foods from his diet and refuses the remainder of his diet, the foods desired should not be given until the undesired portion of the diet is eaten.

Too much activity or insufficient rest is frequently responsible. The child who is very active and plays hard up to the time a meal is served, naturally will not eat. No animal will take food directly after great activity. These children must have rest. All children up to the age of five years should have a daily nap, and the very active children should be given a half hour rest directly before dinner and supper. They should be made to lie down on a couch, and taught to relax.

Coaxing the child to eat merely makes the condition worse. I have seen children amused in the most elaborate manner with all kinds of objects. Each time the child becomes deeply interested in the amusement he automatically and unconsciously opens his mouth when food is put to his lips. Considerable time is spent at each meal in feeding the child in this manner. At the age of two and certainly at the age of two and one-half years the food should be placed before the child, and he should feed himself. If he refuses it, it should be taken away and nothing else given until the next feeding. This should be repeated at each meal. Before very long the patient is hungry enough to take the food. If necessary, at times it is well to give the patient a day of starvation, giving nothing but water for twenty-four hours.

Medicine plays a very minor part in the treatment of this condition. It is true that a little bitters, such as tincture of nuxvomica, is of some additional value at times,

but giving it without correcting the regime is of little value.

Intestinal parasites are occasionally responsible for the poor appetites in these young children, and they must be sought for in all cases not responding to the routine described.

SUMMARY.

Young children with poor appetites should be given proper diets containing no more than a pint of milk daily. They should be fed only at meal time, should never be coaxed to eat, and they should be given sufficient rest and quiet.

A PRELIMINARY STUDY OF THE ANTIBODY RELATIONSHIP OF MEMBERS OF THE STREPTOCOCCUS AND BACILLUS COLI GROUPS*

By **John F. Anderson, M.D., and Emily B. Ellinger, A.B.,**

New Brunswick, N. J.

As a part of the comprehensive research being conducted by Dr. Henry A. Cotton, medical director of the New Jersey State Hospital for the Insane, at Trenton, N. J., into the influence of focal infections on mental disturbances, it has been necessary to make a large number of cultures from stomach washings. Cultures have also been made from material from other sources, such as tonsils, teeth and lymph glands. The organisms most frequently found have been various types of streptococci, colon bacilli, and staphylococci.

For certain reasons attention has to a large extent been focused on the streptococci and colon bacilli and vaccines prepared from members of these groups have been used on rather an extensive scale. These vaccines in part have been prepared from stock strains and in part have been autogenous. The question arose as to the nature of immunity that patient would get from these vaccines. Provided there was antibody production, the stock vaccines might not produce immunity against every strain of streptococcus and colon bacillus; there might be sites of infection missed in getting organisms for autogenous vaccines.

To begin an answer to the question, the following work was done. Two rabbits each were immunized against two strains of streptococci, *Streptococcus pyogenes* and *Streptococcus salivarius*; and two

rabbits each, against two strains of colon bacilli. By means of complement fixation and agglutination tests, and testing each rabbit's serum against each of the four organisms, an attempt was made to find to what extent the antibodies formed were specific or common. The scope of the work so far done does not justify a detailed review of the literature on similar work.

The procedure was as follows: Rabbits weighing about 2,500 grams were used. They were injected subcutaneously over the abdomen. The four antigens for the injecting were prepared as follows: The thirty-six hour growth from ten large agar slants of *Streptococcus pyogenes* 721 T was suspended in about fifty c. c. of .4 per cent. tricesolized physiological saline and killed by heating in a waterbath at 56° C. for twenty-five minutes. This streptococcus was obtained from the tonsil of a patient at the hospital. It is a rather large, gram positive, short chained hemolytic coccus that forms acid on salicin and lactose and no acid in mannit sugar-free agar in forty-eight hours growth. It sediments in bouillon. With the *Streptococcus salivarius* antigen twelve large agar slants were used. Otherwise the procedure was the same as with the pyogenes antigen. The salivarius culture was obtained from a patient at the hospital. It is a small, gram positive, short chained nonhemolytic coccus that forms acid on lactose, no acid on salicin, and mannit sugar free agar in forty-eight hours' incubation. There is a cloudy growth throughout the bouillon cultures.

These two streptococci were typed according to the classification of streptococci, by W. L. Holman (1). For the two colon bacillus antigens, *Bacillus coli communis* and *Bacillus acidi lactic*, the growth from three large agar slants were used for each culture. The procedure was the same as with the streptococcus antigens except that the killing was by heating in a waterbath at 60° C. for one hour. Both the colon bacilli cultures have been described by C. E. Winslow in *Studies on the Classification of the Colon Typhoid Group of Bacteria with Special Reference to Their Fermentative Reactions* (2), and obtained from the collection then in New York at the American Museum of Natural History. *Bacillus coli communis* is a medium sized, gram negative bacillus with small transparent colonies

on agar plates. It gives a positive indol test, forms acid and gas in lactose and sucrose, no acid nor gas in salicin sugar free agar. It has a cloudy growth throughout bouillon. *Bacillus acidi lactic* is a pleomorphic gram negative bacillus with large transparent colonies on agar plates. It gives a positive indol test. It forms acid and gas in lactose, no acid nor gas in salicin and sucrose sugar free agar. It sediments in bouillon to some extent and forms a pellicle at times.

4 of the rabbits, 1 for each of the 4 above mentioned organisms, were treated with gradually increasing doses of antigen over a period of about four months. These were: *Streptococcus pyogenes* rabbit No. 85, received 74.5 c. c. of the antigen; *Streptococcus salivarius* rabbit No. 18, received 68.5 c. c. of the antigen; *Bacillus coli communis* rabbit No. 72, received 80.5 c. c. of the antigen, and *Bacillus acidi lactic* rabbit No. 54, received 79 c. c. of the antigen. Four others, one on each of the test organisms, were treated in the same way over a period of about two months. These were: *Streptococcus pyogenes* rabbit No. 61, received 41.5 c. c. of the antigen; *Streptococcus salivarius* rabbit No. 43, received 43.5 c. c. of the antigen; *Bacillus coli communis* rabbit No. 96, received 33.5 c. c. of the antigen, and *Bacillus acidi lactic* rabbit No. 29, received 39.5 c. c. of the antigen. Four days before the final test and two weeks after the last injection, the animals, with one exception, and a normal rabbit for control, were bled out, the serum obtained inactivated at 55° C. for twenty minutes and .5 per cent. chloroform added. The one exception was *Streptococcus pyogenes* rabbit No. 85 which died. Serum of this rabbit collected ten days before the final test and thirteen days after the last injection was used in the final tests. It had no preservative added and was inactivated at 55° C. for twenty minutes. The serum as described above was used in making the complement fixation tests and agglutination tests together with some anticolon bacillus streptococcus horse serum.

COMPLEMENT FIXATION TESTS.

Method.—Antigens were all less than a week old. They were killed suspensions of pure twenty-four to forty-eight hour agar slant cultures of the respective organisms in physiological saline. The streptococci were killed by heating in a waterbath at 56° C. for twenty-five min-

tes. The colon bacilli were killed by heating in a waterbath at 60° C. for one hour. Before using, the antigens were filtered through several thicknesses of gauze to remove clumps. They were titrated with the hemolytic system reagents used in making the tests and one half the anticomplementary unit was used as the dose of antigen.

The setup for the tests was: .1 c. c. serum dilution; .7 c. c. antigen solution, and .1 c. c. guineapig complement. The tests were placed in the waterbath at 37.5° C. for one hour. Then .1 c. c. sensitized sheep red blood cells, a 2.5 per cent. suspension of packed cells, added. After another hour at 37.5° C. in the waterbath, the tests were placed in the icebox overnight and read in the morning. Readings were recorded as follows: ++

+ complete fixation; +

++ almost com-

plete; ++ fixation; + small amount of fixation; | few red blood cells in bottom of tube; — negative. The hemolytic system, serum and antigen controls were all negative. There was no hemolysis in the corpuscle control. These controls were run in duplicate.

AGGLUTINATION TESTS.

Method.—The antigens were saline suspensions of pure twenty-four to forty-eight hour agar slant cultures of the respective organisms, emulsified with glass beads, filtered through gauze to remove clumps, and contained about one billion organisms to the c. c. The setup of the tests was: .5 c. c. serum dilution, and .5 c. c. antigen. The tests were placed in the incubator at 37.5° C. overnight and readings then recorded as follows: |||| complete agglutination; ||| almost complete; || partial; | few agglutinated; + doubtful — negative. Antigen controls were run in duplicate. They were negative with the exception of the *Streptococcus pyogenes* antigen. Since it agglutinated spontaneously the tests with it were not read.

SUMMARY.

There was practically no common complement fixing body or agglutinin production by members of the streptococcus and members of the colon bacillus groups. *Streptococcus pyogenes* showed little complement fixing body production with results at variance. It had no agglutinin production for *Streptococcus salivarius*. *Streptococcus salivarius* showed little

complement fixing body production but that was specific. It had fair agglutinin production. *Bacillus coli communis* showed complement fixing body production more specific for itself than for *Bacillus acidilactici*. Its agglutinin production was almost completely specific. *Bacillus acidilactici* showed complement fixing body and agglutinin production practically common with *Bacillus coli communis*.

CONCLUSIONS.

There was practically no common complement fixing body and agglutinin production by members of the streptococcus and members of the colon bacillus groups. The complement fixing body and agglutinin production by *Streptococcus pyogenes* and *Streptococcus salivarius* seemed on the whole to be specific. *Bacillus coli communis* had rather a specific complement fixing body and agglutinin production while that of *Bacillus acidilactici* was practically common with *Bacillus coli communis*. Work of this nature using many more strains as antigens should be done.

REFERENCES.

1. Holman, W. L.: *Journal of Medical Research*, July, 1916.
2. Winslow, C. E.: *Journal of Bacteriology*, Sept., 1919.

UNTOWARD RESULTS OF INTRA- VENOUS INJECTION OF SODIUM IODIDE.

By L. Isacson, M. D.,
Sioux City, Ia.

At present, the method of applying medication by the intravenous route is greatly in vogue in the profession; rheumatic conditions, complications of gonorrhea, and all kinds of chronic ailments have been subjected to intravenous injections of foreign proteins, vaccines, and all the chemical agents of our pharmacopoeia. The commercial firms putting up these preparations are constantly advertising the splendid results of some workers, while unfavorable or untoward effects are never mentioned.

I wish to report a case of gonorrheal epididymitis, which has been under my care for the past six weeks. Impressed especially by the article of A. Ravich in the *New York Medical Journal* of May 3, 1923, I employed the sodium iodide treatment.

Case.—C. G. came for treatment on March 1, 1922, with a chronic epididymitis. The swelling of the epididymitis had been present for ten days there was extreme pain,

the temperature being 100° F. Fifteen grains of sodium iodide were injected intravenously, a comparatively small dose, the average amount recommended by Ravich and others being thirty grains. The following morning I was called to the patient, who was confined to his bed, presenting a striking appearance: The upper left eyelid was markedly swollen, together with enlargement of the salivary glands; the patient experienced a great deal of difficulty in opening his mouth, owing to extreme pain. On both hands and forearm there was an extensive erythematous, papular dermatitis, with subjective symptoms of itching and burning; later some serous exudation developed on the left forearm. The patient complained of violent headache, nausea, chills, vomiting; he was confined to his bed for three days, until all symptoms subsided.

The preparation used was made by a well-known drug firm, was taken directly from the container and injected with all aseptic precautions with the Luer syringe.

I believe that all of the symptoms in this case were the result of the mode of administration, and were not due to any idiosyncrasy on the part of the patient, as prior to injection tincture of iodine was applied to his skin and no reaction observed. Subsequently, we gave the patient two grams of sodium iodide by mouth, with no outward effects. While this is an isolated case, and no definite conclusions can be arrived at, I feel that this experience is enough to warrant my making the statement that a halt should be called upon promiscuous intravenous therapy.—A. M. A. Jour.

Third: Functional nervous disorders which are purely physiologic. These are the physiologic psycho-neuroses. Dr. Williams explained these disorders as due to the behavior excited by objects which have repulsive effects on one individual while pleasurable effects on another individual. In other words the one individual properly interprets the situation while the other individual uses improper interpretation, and these interpretations depend upon an old series of experiences which have reacted favorably or unfavorably, as the case may be, to the individual. Hence these psycho-neuroses are caused by a faulty aperception of situations. The treatment is to educate the individual by showing them the real nature of the situations and by changing their point of view to the situations. It is a question of making the patient understand himself and to properly adapt himself to situations through their proper interpretation.

Dr. Miller emphasized the importance of certain laboratory tests in the recognition of certain blood diseases. These tests were as follows: The estimation of urobilin in the urine, of hydrochloric acid in the gastric juice, the fragility of the red blood cells, platelet counts, coagulation time and bleeding time of the blood, reticulated red blood cells, and blood calcium. Among other uncommon blood diseases he took up the laboratory diagnosis of purpura hemorrhagica and hemophilia. In purpura hemorrhagic the bleeding time of the blood is greatly increased, the platelets are reduced in number and blood calcium is normal. In hemophilia, which is a disease always occurring in males and never in females although transmitted by the latter, there is a marked increase in the coagulation time of the blood, the platelets are normal in number but are defective in quality, and the blood calcium is normal. The fact that the blood calcium is normal in both of these conditions is worthy of note for it is a common error to administer calcium in these cases in which it is not at all indicated.

BERGEN COUNTY.

Dr. Frederick S. Hallett, M.D., Reporter.

The regular monthly meeting of the Bergen County Medical Society was held at the Hackensack Hospital, January 8th, at 8:30 P. M. The president, Dr. George L. Edwards called the meeting to order. About forty members being present and several guests.

The following applicants were elected to membership:

Drs. Edward Reed, Garfield; S. T. Dayton, Englewood.

Dr. Hallett called attention to the necessity of taking proper care of our mental cases. It has been the custom in Bergen County to commit these unfortunate persons to the county jail for observation.

After discussion, the chair approved Drs. Armstrong, Bell and Conrad to confer with the Board of Freeholders and make recommendations.

The paper of the evening was read by Dr. C. C. Beling of Newark, "Mental Mechanisms and Mental Therapy." The doctor presented his subject in a very interesting manner and it was much enjoyed by those present.

County Medical Societies' Reports

ATLANTIC COUNTY.

Royal E. Durham, M.D., Reporter.

The regular monthly meeting of the Atlantic County Medical Society was held at the Hotel Chalfonte, on Friday evening, December 14th, 1923, at 8:30 P. M. Dr. Tom A. Williams of Washington, D. C., spoke on "Functional Nervous Disorders: Their Meaning, Mechanism and Management." Dr. Sidney R. Miller of Baltimore, Md., spoke on "The Proper Recognition of Certain Uncommon Diseases of the Blood."

Dr. Williams divided functional nervous diseases into three classes as follows: First Functional nervous disorders due to alteration of the structures of the nervous system. In these cases the organic factor may be very slight and easily overlooked and a diagnosis of a psycho-neurosis is very apt to be made. Second: Functional nervous disorders caused by improper chemistry of the nerve cells. The toxemias such as typhoid fever and alcoholism, etc., focal infections and the glandular disturbances come under this heading. These are secondary psycho-neuroses.

BURLINGTON COUNTY.

Daniel F. Remer, M.D., Reporter.

The Burlington County Medical Society met in Mt. Holly on Wednesday, January 9th, 1924 in its annual meeting. The president, Dr. Harry Rogers of Riverton presided.

The following officers were elected for the coming year:

President, Dr. J. E. Dubell of Columbus; Vice-President, Dr. H. E. Longsdorf of Mt. Holly; Secretary and Treasurer, Dr. Geo. T. Tracey of Beverly; Reporter, Dr. Daniel F. Remer of Mt. Holly.

Annual Delegates to the State Society: Dr. Edgar J. Haines of Medford; Dr. Lyman B. Hollingshead of Pemberton.

Chairman Section on Medicine: Dr. E. K. Mulford, Burlington; on Surgery, Dr. H. Butler, Moorestown; on Obstetrics Pediatrics, Dr. Elmer Stokes of Moorestown.

Delegate to Atlantic County, Daniel F. Remer; Salem County, W. M. Newcomb; Gloucester County, H. M. Bauer; Cape May County, Alexander Marcy.

Permanent Delegate to State Society: Daniel F. Remer.

Dr. John B. Morrison, the newly elected Secretary of the State Medical Society then spoke to the society on points of special interest.

Dr. Harry Rogers, the retiring president, read a very good paper on "Focal Infection."

The society adjourned to meet in Burlington in April.

CUMBERLAND COUNTY.

Elton S. Corson, M.D., Reporter.

The Cumberland County Medical Society held its quarterly meeting at the Hotel Commercial. Dr. P. C. Lummis presided.

Communications were read from Dr. J. B. Morrison, Secretary of the State Medical Society, regretting his inability to attend the meeting, owing to his illness, and Dr. Irving E. Charlesworth, of the Veterans' Bureau, San Francisco, Cal., who asked for a transfer to the San Francisco Medical Society.

Drs. Burton Walker, Millville; Edward Horner Egbert, and Edward Van Dusen, Vineland, were elected members.

The Periodic Health Examination, with the slogan, "Go to your physician on your birthday," as indorsed by several health organizations was endorsed.

Dr. E. C. Lyons reported on the Cumberland County Milk Commission and through him Isaac L. Shoemaker invited the society to hold a meeting at the Shoemaker Dairies and inspect the plant.

Dr. W. L. Cornwell facetiously introduced Dr. Edward J. Klopp, of the surgical staff, Jefferson Medical College, as the speaker of the day. He said Dr. Klopp, his classmate, was unknown to fame until he operated upon James J. Corbett.

Dr. Klopp chose for his subject: "Acute Conditions of the Abdomen." They comprise those of the stomach, spleen, liver, gall bladder, appendix, intestines, bladder, female organs. Some of these simulate all of them and require careful differentiation. Distinction should be made between inflammatory and non-inflammatory conditions. 80 per cent. of cases of appendicitis begin in the night. Avoid

the use of purgatives until the diagnosis is made nor should morphine be given previously. Be careful of the delusion state of appendicitis. This occurs with the beginning of gangrene when the pain subsides or disappears. There are no definite symptoms for acute pancreatitis.

Dr. Walt P. Conway, District Councilor, spoke of conditions affecting the welfare of the physicians. The meeting was well attended, and all enjoyed the dinner provided by Mrs. Gosbin. The next meeting will be held at the Weatherby House, Millville.

ESSEX COUNTY.

Alfred Stahl, M.D., Reporter.

The Essex County Medical Society met on December 6th and after routine business, which included consideration of forth-coming legislation at Trenton, listened to an address by Major C. M. Sampson, M.D., on "Physio-Therapy" with which the aid of moving pictures, revealed the character of work done by the U. S. Army, notably at Fox Hills, in reconstruction of disabled soldiers. The importance of the subject and the excellence of the pictures, demonstrating the means used, elicited enthusiastic interest in an audience which was the largest, except at the annual meeting, which the County Society has known in years. The Essex County Medical Society met again on January 10th. Among the items of business was a report by Dr. Eagleton, Chairman of the State Welfare Committee and the statement that the newspapers of the State were being circularized to ask whether they would follow the plan of the Passaic Daily News has announced, that "it would not publish any mention of law-suits instituted against members of the medical profession, abolish that unjust injury to a doctor's reputation until court action ensued. This policy would tation, which the mere announcement of a blackmail suit may cause. It would be only what, in justice, newspapers should recognize as news.

Announcement was made of another victory for the State Society's defense against malpractice suits, in that the court had nonsuited a plaintiff in a suit against two of our members, for commitment to asylum. The address of the evening was a most excellent one, by a master in research work, Dr. H. W. Haggard, a co-worker with Dr. Yandell Henderson at Yale University, on the important subject of "Resuscitation from Gas Poisoning, Drowning, Electric-shock and Anesthesia Collapse." The subject is of extreme importance because of—

1. The increasing number of such cases, especially gas-poisoning and electric-shock.

2. The great and prevailing mistake of using mechanical apparatuses, two of which are especially energetically pushed by the makers and are faulty for artificial respiration, even if they are immediately at hand, which is almost never the case. For the research work, Dr. Haggard stated, that the utmost limit of life, after cessation of breathing, is ten minutes and therefore life must depend upon the first aid worker who immediately arrives. The only means now recommended by the medical profession and the industrial corporations, the Electric Light and Transportation and Gas Companies, all having

worked together to improve treatment of these cases, is artificial respiration by manual method and this preferably by the Schaffer Prone Pressure method, which is so simple, easily applied, not tiring to the operator and can be begun immediately.

GLOUCESTER COUNTY.

Henry B. Diverty, M.D., Reporter.

A meeting of the Gloucester County Medical Society was held Thursday afternoon, January 17th, at the Stoerrie Hotel, that city, with an attendance of nearly 100 per cent.

Owing to the illness of Dr. Charles P. Noble, a recognized authority on women's diseases, Dr. James Hunter of Westville, addressed the society upon the relation of the county society to the State Society. Following the address a very enthusiastic discussion was held on smallpox and diphtheria.

Dr. Emma Richardson, delegate from the Camden County Society; Dr. John H. Moore and Dr. Walter Glenden, delegates from the Cumberland County Society and Dr. Joseph Husted, delegate from the Salem County Society, were presented as was also Dr. J. B. Turner, an eye specialist. Short addresses were made by the delegates and visiting specialist.

Report was made to the society that the State has a population of 3,155,900 and that there are 3,362 physicians of whom 2,127 are members of the State Medical Society. An advantage of being a member of a county society is that the member is eligible to membership in the State Society and the American Medical Society.

HUDSON COUNTY.

William Freile, M.D., Reporter.

Almost the entire evening of January 2, 1924 was given up to a talk before the Hudson County Society at the City Hospital, by Dr. S. Franklin Adams of the Mayo Clinic, Rochester, Minn., a son of Dr. Samuel Adams of Jersey City. His subject was "A Consideration of the Present Status of the Diabetic Patient with Reference to Insulin."

He stated that more has been learned about diabetes in the last few years than during the preceding ten centuries. He called the experiment of depancreatizing a dog; it was noticed that the animal's urine attracted flies and hence diabetes was eventually located in the pancreas. With the isolation of adrenalin, thyrotoxin, etc., it was natural to look for something to occur in connection with diabetes and so Banting's discovery was opportune. As with most diseases time checks up and proves their usefulness, limitations, etc., so it has been already shown that insulin is worthless unless used in conjunction with carefully selected and weighed diet. This conclusion has been arrived at by Allen, Jocylan and many others working on this particular line of action. He deplored the starving of patients to within an inch of their lives and explained the Schaffer 4-1 ratio, where a certain amount of fat must be balanced by a fixed quantity of sugar, thus enabling a diabetic to utilize enough food for the production of energy commensurate with their station in life, etc. He compared the diabetic patient to an engine. If an engine becomes defective and is pushed, it will wear

down; spare it and it will do its best to continue operating. Most diabetics have a mild type of disease and if the diet is properly arranged insulin will not be necessary.

In the severe type, where the necessity for work is paramount, enough food should be given and enough insulin to enable the patient to take care of it and thus keep him going so to speak. Ward patients have to get back to their jobs and they therefore use more insulin than private patients.

The speaker threw on the screen a food scale by means of which definite ratios and proportions were quickly ascertained and readily transposed into actual food. Thus the patient was given a prescription for food just as one would write for a medicine and this enabled long distance cases to be taken care of by mail. The doctor next spoke in detail in basal diet; exhibited a chart showing the amount of sugar going into the body; showed the development of the insulin unit and discussed tolerance thereto.

A chart was next presented showing the incidence of mortality in surgical operations on diabetics, prior to and following the introduction of insulin, demonstrating that with the proper use of this agent the death rate for minor and major operations compared favorably with that of any large general hospital. In diabetics after a trifling operation may provoke an acidosis which may be produced by dehydration or something of that sort. He emphasized that while insulin was a great aid to surgery it was not altogether a life saver and that the necessity for minimum handling and speedy execution was still present.

On account of the large percentage of diabetic gangrene of the feet, Jocyn of Boston insists on special care of the extremities, cleanliness, exercise, anointing with lemon juice, wearing new shoes only half an hour a day. Coma cases are just as serious as ever, but when regarded as transitory and properly located many recoveries ensue, giving the usual things, fluids, soda, supporting the heart and giving insulin, although this has not yet been available enough to say how much it will do in the cure of coma.

Insulin has taken helpless individuals, put them back to work and enabled them to become useful members of the community and less of a burden to their friends or a tax to the State.

Dr. Rosencranz on opening the discussion spoke of his interest in this work and of Jocyn's ideas of diet. He believed that overfeeding put too much work on the heart. He had learned that when a patient complained of pains of infection in the groins to look to the feet. Dr. Van Densten did not think insulin yet practical enough for the general practitioner and thought there was need for establishing diabetic clinics. Dr. Natrass told of three cases that did not respond to any doses. Drs. Shapiro of Bayonne, and Louis Pyle also discussed cases.

Dr. Adams in closing, stated that he advocates hospitals for diabetics, but many who need insulin could not remain in institutions; for these out-patients departments were being formed, where attending physicians at fixed hours gave a short course of instruction on diet, food tolerance and general care, in many

of the mild cases, allowing the proper amount of carbohydrates protein, and a fair amount of fat, eliminating insulin which would complicate the patient's existence.

Before the advent of insulin the combination of tuberculosis and diabetes was helpless, one lesion indicating starvation and the other the reverse. Now 3,000 calories can be given and enough insulin to burn this and the unfortunate victim has a chance. The results in gangrene were very encouraging. The exhibition of insulin permitted of more conservative and safer surgery and persons with early superficial lesions of the toes have had promising results. Whether diabetes is increasing is not positively known. In the last ten years everybody has been on the lookout and probably more cases are being found.

The anaesthetic in surgical diabetes in 50 per cent. has been ether and when the operation has been done quickly the result has been good. In other cases gas and oxygen alone or combined with ether has been used. In reference to a case that was cited where a person gets up without sugar in the urine with high blood sugar and then as his blood sugar gets low he has a good deal of sugar in the urine he did not know how to account for it. Emergency coma cases are given 30 units subcutaneously, 25 grains of soda in 3 per cent. solution intravenously; they are kept warm, if necessary in an hour 30 more units are given. It is necessary in these cases to give plenty of sugar to avoid insulin shock. He referred to intavin stating that it was a fat introduced by Max Kahn of New York and stated its function in the treatment of diabetes and said if insulin could not be had it would be valuable although it did not equal insulin.

A rising vote of thanks was given to Dr. Adams for his extremely interesting and helpful address.

MERCER COUNTY.

A. Dunbar Hutchinson, M.D., Reporter.

The following is a report of the proceedings of the meetings for October, November and January of the Mercer County Society. Owing to pressing matters relative both to hospital and private affairs, the secretary was unable to forward to you on time, reports of these several meetings as they occurred.

This County is rapidly obtaining the membership of all physicians practising within its borders, and our hope is to attain 100 per cent. in the near future. We have elected nine new members within the past year, with two applications now in the hands of the committee. The meetings are well attended, and in view of this fact, a committee has been appointed by the president to obtain information relative to a professional building, where meetings both public and private may be held.

The October meeting was largely attended, as the president, Dr. Cotton at that time, expected to report on his visit abroad. He gave a very entertaining and instructive report of his trip, describing in detail many of the new processes being applied in mental conditions. He expressed in high terms the sincerity of the hospitality that was accorded him personally by many of our foreign colleagues, and in the several institutions that he visited.

The annual banquet of the society was held in November, there being present 86 guests,

who were royally entertained during the sumptuous repast by several speakers of renown.

The society went on record at this meeting as endorsing the work of the N. J. Health League, which at that time was starting a campaign of education in the fight against tuberculosis.

The members of the society offering their services as speakers in the many public meetings scheduled.

The December meeting is the annual, with the election of officers for the ensuing year:

President, Dr. Alvan W. Atkinson; Vice-President, Dr. Daniel L. Haggerty; Secretary and Reporter, Dr. A. Dunbar Hutchinson; Treasurer, Dr. Harry R. North. Board of Censors: Drs. G. N. G. Sommer, G. R. Moore, Wm. G. Schaufler.

Membership Committee: Drs. Chas. F. Adams, Walter D'Arcy, James J. Maguire.

Program Committee: Drs. D. B. Ackley, Edgar L. West, L. H. Rogers.

Annual Delegates: Drs. Wm. D. Olmstead, Harry R. North, M. W. Reddan, D. B. Ackley, F. G. Scammell. Alternate Delegates: Drs. H. D. Bellis, D. L. Haggerty, R. W. Davison, H. D. Williams, P. B. Means.

Member of Nominating Committee: Dr. James J. McGuire.

The January meeting was the banner meeting, about 40 of the membership attending.

Dr. Milton J. Raisbeck, a renowned specialist on heart diseases, gave us a most enlightening evening on the subject "Diseases of the Heart in Pregnancy and Other Conditions." This address was so entertaining and instructive, that following the concluding remarks of the able speaker, a special request was sent the secretary that Dr. Raisbeck be invited to again address the society in the near future.

Drs. Child, Stone, Yaeger, Rosenthal of Trenton; Drs. Hale of Princeton and Proctor of Allentown were elected to membership.

MONMOUTH COUNTY.

Harvey S. Brown, M.D., Reporter.

The annual meeting of the Monmouth County Medical Society was held on December 11th, 1923, at the American House in Freehold, and was called to order at 12.30 P. M. by Dr. G. Van Voris Warner, president.

Members present: Drs. Warner, Fairbanks, Clayton, Magee, Herman, Beveridge, Holters, Shaw, Silcox, Campbell, Sassidy, Hartman, Brown, Bryan, Gesswein Beach, Garrison, Knecht, Wilbur, Tilton, Hauseman Watkins, Ingling, Robinson, Anderson, Van Mater, Hendrickson, Hepburn, H. B. Slocum. The secretary reported eight meetings of the society held during the year with an average attendance of 14. The president and Dr. Brown were high on attendance.

The treasurer reported a balance of \$452.73. The reporter stated he had reported several meetings to the State Journal. Dr. Slocum gave his report of attendance at the Annual Meeting of the State Society.

Resolution: That the Committee from the Society functioning with Mental Welfare Clinics be broadened to function with Monmouth County Organization on Social Welfare. This was passed.

Discussion concerning attendance at meet-

ings were entered by Drs. Magee, Warner and Herman.

Dr. Warner who had the honor to serve the society for two years as president, was given a vote of thanks and a committee was appointed to present him with a token for his service.

After the usual dinner, the president's report was received and filed, and the following officers were elected for the year 1924:

President, Dr. Harvey W. Ingling, Freehold; Vice-President, Dr. W. G. Herman, Asbury Park; Secretary, Dr. J. C. Clayton, Freehold; Treasurer, Dr. O. R. Holters, Asbury Park; Reporter, Dr. Harvey S. Brown, Freehold.

Annual Delegates: Drs. J. H. Fisher, Asbury Park; B. H. Garrison, Red Bank.

PASSAIC COUNTY.

Louis G. Shapiro, M.D., Secretary.

The last meeting of the Passaic County Medical Society was called to order by President John N. Ryan, January 10, 1924, at 9 P. M. in the Chamber of Commerce Rooms, Paterson. Forty members were present.

The scientific program consisted of two papers. The first on "Congenital Pyloric Stenosis," was read by Dr. Walter M. Winters of Paterson. The following facts were stated in a very interesting manner: The infrequency but grave seriousness of the disease; the importance of early recognition of the condition. Most of the infants are breast fed. Persistent vomiting under these circumstances should arouse suspicion. A neuropathetic tendency is perhaps the greatest factor in the origin of the disease. The symptoms usually appear before the sixth week and consist of frequent vomiting, becoming projectile in character; constipation, stools that are scanty and that later consist merely of dark brown mucus; scanty urine; rapid loss of weight; scaphoid abdomen with fullness of the epigastrium; visible peristalsis and at times palpable tumor. The medical treatment consists of lavage, the application of heat to the epigastrium and the administration of milk. Mother's or cow's milk with low fat contents or Dryco milk powder, of value also because of its low fat; or the administration of thick cereal mixtures, with or without the addition of milk. The cereal mixture because of its adhesive qualities is less readily vomited. The only drug worthy of discussion is atropine. The dose to commence with is 1/1000 grain, given in each feeding. This should be increased to the point of saturation as shown by flushing. The writer stated that he had no experience with the hypodermic use of atropine in these cases.

Medical treatment should be given a thorough trial but should not be persisted in, if steady loss of weight continues. The child should be given the benefit of operation before reaching the moribund stage. The Ramstedt operation is the one of choice and has yielded a mortality as low as 10 per cent. Post-operative feeding should be done with great care.

Discussion followed. Dr. A. Ward Van Riper warmly commended the use of thick cereal mixture and emphasized the importance of giving water by injection; in one case he had given it intra-peritoneally. He further called attention to the diagnostic value of x-ray, complete retention after three hours indicat-

ing stenosis rather than spasm. Drs. Wm. Spickers and Thos. A. Dingham commended on the infrequency with which these cases have come to operation in Paterson, and on the technique of the operation. In all four cases had been operated on, with one recovery. A point to be remembered is the possibility of opening the duodenal mucosa in incising the tumor.

Dr. Roemer stated that retention of a barium meal for three hours did not mean stenosis unless the administration of atropine hypodermically had ruled out spasm. Dr. Murray Bass commented briefly on his experience with the use of atropine, hypodermically in this disease. The atropine is well tolerated. As much as 1/12 grain had been given in one day. The results at times were gratifying. The discussion was closed by Dr. Winters.

The second paper, on "Tuberculosis in Children" was read by Dr. Murray Bass of New York City. Dr. Bass confined his address to one phase of the subject, namely tuberculosis of the lungs in children and emphasized the following points:

The problem of preventing tuberculosis is that of the prevention of tuberculosis in children. The chief mode of infection is by inhalation, through contact with human tuberculosis. In this country, only a minority of the infection is of bovine origin, about 10 per cent. The primary infection as worked out by Ghon, is situated in the lungs, usually in the apex of the right lower lobe. This lesion may be quite minute and difficult to demonstrate. From this initial lesion, the infection spreads to the regional lymph nodes at the hilum.

Dr. Bass aptly compared the spread of tuberculosis infection with the dissemination of syphilis. If the primary focus in the lung be considered the initial lesion, the involvement of the hilum corresponds to the invasion of the regional lymph nodes, while the dissemination of the tuberculosis, as an acute miliary tuberculosis or by involvement of the skin, glands, bones or kidney is some what analogous to the secondary stage of lues. Massive involvement of lung parenchyma with cavity formation is comparable with the third stage of syphilis. The types seen in children are the primary infection, the hilum lymph node cases, solitary secondary lesions of bone, kidney or glands and acute diffusely disseminated miliary tuberculosis. Tuberculosis of lung parenchyma with necrosis is distinctly an adult type of the disease very rarely seen in children. When encountered, it is usually in children of nine years or older.

Dr. Bass quoted interesting results of experimental work. Primary inoculation of guinea pigs ever produced lung involvement comparable with human pulmonary tuberculosis. Subsequent re-inoculation of guinea pigs does produce lung lesions rather similar to the human adult type. The primary infection, in some manner sensitizes the lung and renders it especially vulnerable to later infection. This rather elucidates the process in man. In this light, tuberculosis in children is the result of the primary invasion, while adult pulmonary tuberculosis, is the consequence of super-added infection. Hilum tuberculosis is frequently associated with characteristic cough, brassy and at times spasmodic, suggesting whooping cough.

Dr. Bass then discussed three types of tuberculin tests: The percutaneous, called the von Pirquet test; the intracutaneous, and the subcutaneous. The skin reaction in the von Pirquet is dependend upon a condition of allergy that requires six weeks to develop after tuberculous infection has occurred. On this account a child born of a mother with open pulmonary tuberculosis does not give a positive skin reaction until the sixth week. Experimental work has proven that a positive skin test is indicative of the existence of tubercles in the body. The von Pirquet test is less sensitive than the other tests, but is better fitted for clinical use. The intracutaneous test can be employed when the von Pirquet test gives negative results and is preferable for scientific studies. The subcutaneous tuberculin test is similar to the one employed for adults, except that smaller doses are used.

The remainder of the lecture was devoted to the demonstration of a series of lantern slides illustrating the various forms of pulmonary tuberculosis occurring in children, namely: Various instances of primary lesions of the lungs, hilum tuberculosis, tracheomiliary tuberculosis, spontaneous pneumobronchial lymph node tuberculosis, acute thorax and two cases of the adult type of lung tuberculosis with cavity formation.

After discussion by Dr. O. R. Hagen and others, a motion was carried that a rising vote of thanks be given Dr. Winters and Dr. Bass for their interesting and valuable papers.

UNION COUNTY.

Russell A. Shirrefs, M.D., Reporter.

A meeting of the Union County Medical Society was held at the Elk's Club in Elizabeth, on the evening of January 9th. A large attendance greeted the speaker of the evening, Dr. J. B. Morrison of Newark, Secretary of the State Medical Society. He discussed among other things, the subject of "diploma mills" and regular practitioners, and explained how the matter is being handled by the State Board of Medical Examiners. Dr. Chas. H. Schlichter was elected as the representative of the society in the State Gorgas Memorial Association. An endowment fund of \$5,000,000 is being raised for the erection of a memorial to Dr. Gorgas, former surgeon-general of the U. S. Army, and known throughout the world for his work on sanitation, and his success in stamping out disease while working in the Panama Canal Zone. The society, following the receipt of a letter from the State Board of Examiners, went unanimously on record as opposed to the re-issuing of a license to Dr. I. Alfred Lawrence, who was convicted of performing illegal operations. The treasurer's report showed the comfortable balance of \$940.25. Dr. Frank L. Foster of Cranford was elected to membership, and another candidate was proposed.

Local Medical Societies

Bayonne Medical Society.

M. I. Marshak, M.D., Reporter.

The January meeting of the society was held January 21, Dr. Harvey presiding in the absence of President Chayes.

Dr. Donohue reported a case in which he curetted the uterus after the removal of a uterine polyp. Three weeks later the woman aborted a foetus which seemed to be about two or three weeks old.

Dr. Frank reported a case in whom he had done a curettment for an incomplete abortion in May of 1923. He delivered this woman of a full time child in January of 1924.

Dr. Woodruff discussed three cases of kidney lesions, in which pain was a marked symptom. After a regular routine diagnostic procedure, finding lack of function on one side he removed that kidney. On section the removed kidney showed the typical picture of chronic interstitial nephritis. He thought that the pain was probably due to the passage of clots following some kidney hemorrhage.

Dr. Forman gave a talk on more team work in our local, county and State associations, and made a plea for the members to more actively support the State Society's Welfare Committee.

Dr. M. Frank then read a paper on "Common Orthopedic Conditions." He took up in detail the etiology, pathology, diagnosis and treatment of the following conditions: Flat feet, anterior metatarsalgia, hallus valgus, hammer toe, bow legs and knock knee, club feet and back ache. He laid special emphasis on the anatomy and physiology of the foot and on the fact that early thrombo-anglitis obliterans is frequently diagnosed as flat feet and gave the differential points of diagnosis.

Physicians of Montclair and Vicinity.

The Associated Physicians of Montclair and Vicinity met December 17th, 1923, and listened to a timely and interesting paper on fractures, by Dr. Joseph A. Blake, former Colonel, Medical Corps, U. S. A., Director of Reconstruction Hospital, New York City, and Director of Paris, France, Hospital Center. His subject was a "Campaign for the Better Treatment of Fractures" and outlined the factors which constitute the present-day care of fractures which have often been the cause of great disability in the patient and great concern to the surgeon. Of all the gun-shot injuries in the war, those involving bone and joint disabilities, were in the majority and the experience of all the armies lead to improvement in their care, greater than known before in equal time. The American and British Medical Corps, under such masters as Major-General Robert Jones on orthopedics, and Alexis Carrel, in infection, have led the way to great improvements in treatment, among which suspension apparatus and standardization of splints, were parts of Dr. Blake's instructive address.

Summit Medical Society.

William J. Lamson, M.D., Secretary.

The regular monthly meeting of the society was held at the Canoe Brook Country Club, on Friday, January 25, 1924, at 8.30 P. M., Dr. Bowles entertaining and the president, Dr. Lawrence in the chair.

Present: Drs. Alexander, Bensley, Bowles, Campbell, Clark, Dengler, Falvello, Keeney, Krauss, Lamson, Lawrence, Meeker, Meigh, Milligan, Moister, Morris, Pollard, Prout, Reiter, Smalley, Tidaback and Wolfe, and the fol-

lowing guests: Drs. Green and Banker of Elizabeth; Dr. Frost of Morristown and Drs. Byington and Kende of Summit. A letter of regret was read from Mr. Thos. M. Debevoise, secretary of the American Society for the Control of Cancer.

A communication was read from the Welfare Committee of the State Society, outlining the program of health legislation to be introduced at Trenton this winter, and urging its endorsement by physicians. On motion the secretary was directed to write to the senators and representatives, urging that these proposed bills, viz., the Marriage Bill, the Venereal Control Bill and the Sterilization Bill, be passed, and that the Society unanimously endorse them.

An invitation was received from the Civic Club of Summit, to a dinner to be given by the Club to the doctors of Summit, at the Y. M. C. A., on February 7, 1924.

The paper of the evening was read by Dr. H. H. Bowles, on "Cancer from the Modern Standpoint." He summed up in a thorough and painstaking manner, all that has been done toward discovering its etiology, which is still baffling the profession. A brief description of symptoms and treatment followed. Surgery has advanced as far as it can go toward cure, and, except for superficial types of cancer, is unsatisfactory as regards cure. X-ray, diathermy, radium, fulguration and other forms of treatment are all of benefit in selected cases. He deplored the valuable time lost in arriving at a correct diagnosis, and again in getting the patient under surgical treatment.

The discussion showed a general vein of pessimism among those present as to any other treatments than those we now have, although some looked for a solution of the problem in the near future.

Newark City Hospital Staff.

Raymond J. Mullin, M.D., Secretary.

The medical staff of the hospital at the clinical meeting which followed the regular meeting was addressed by Dr. Edward J. Ill, representing The American Society for the Control of Cancer.

After a brief review of the history of the association, Dr. Ill pointed out the fact that they soon learned that it was impossible to accomplish much by appealing solely to the public and that the chief difficulty was with the doctors, particularly those who did not attend society meetings and were not associated with hospitals, he emphasized a few important points regarding the diagnosis of cancer. He mentioned the following facts: That pain is a late symptom; that it is wrong to operate on hopeless cases; that where there is glandular involvement the case is practically hopeless; that where the glands cannot be readily separated from the vessels, operations are seldom successful. A simple test for carcinoma "a curette that will cut into tissue like it will in cheese" makes an absolute diagnosis. The earlier the diagnosis, the surer you are to get good results.

Fever occurs in a certain percentage of cancer cases. Sarcoma frequently produces fever. He called attention to an article by Briggs on Fever in the American Journal of Medical Sciences in which 52 per cent. had fever in carcinoma of the liver and 30 per

cent in carcinoma of the lung. Osler and Friedenwald studied fever in carcinoma and as long ago as 1865 fever was mentioned in carcinoma cases. It is most common in general glandular sarcoma. Dr. Ill stated that he believed carcinoma to be a germ disease and he prophesied the eventual discarding of operative, light, x-ray therapy, etc., and the introduction of intravenous injections for treatment. Dr. Worl asked about the contagiousness of carcinoma and Dr. Ill said that he did not consider it contagious, infectious or hereditary.

A general discussion ensued.

Dr. Haussling took exception to the criticism of non-hospital doctors and advocated circularizing this class along lines used by pharmaceutical houses. He emphasized the fact that early diagnosis is the crux of the question, and stated that in his opinion the treatment of carcinoma was more chaotic at present than ever before. He has seen some wonderful results from radium and x-ray but in watching these cases he felt that the radiologist often does more harm than good, and feels they should have surgical experience. He hoped that Dr. Ill's prophecy will come true but still feels that there is a large field for surgery in malignant diseases. He criticized the prognosis usually given by the radiologist. Dr. Kraker spoke of the infrequent use of the Proctoscope by general men, thus eliminating possible early diagnosis of rectal carcinoma cases. He also emphasized the necessity for early diagnosis. Dr. Eagleton said he could not subscribe to the statement that a large part of the profession does not try to make an early diagnosis and advocated the widest possible publicity while decrying the natural tendency of the profession to avoid publicity on this and all matters.

Dr. Teeter asked, "even though an early diagnosis is made, what have you to offer"? He cited the record of the Peter Bent Brigham Hospital in which one per cent. cure in early cases was reported; carcinoma of the breast, early removal followed by radiation four per cent. cures. He felt that the subject was a laboratory one and should be approached from that angle. He emphasized the fact that we need a careful, wide, statistical study of early and late cases to learn how many can be cured. Dr. Baker said that he had just come from the Mayo Clinic where 75 per cent. cure after five years is claimed. He advocated closer co-operation between medical, surgical and other branches of the profession, rather than the present-day tendency to antagonize and criticize, mentioning that the radiologists have co-operated. He quoted Dr. Bloodgood who states that if a woman has carcinoma today, she should have it out tomorrow. Dr. Sprague feels he can notice the results of the educational propaganda on the public with beginning good results. He does not think that the treatment is as gloomy as Dr. Teeter claimed. He said Halsted's work is very encouraging and mentioned the fact that carcinoma of the oesophagus was one of the most depressing types to him as the symptoms appeared late and the mortality was 100 per cent. Dr. Pinneo advocated getting into the lay press.

Dr. Wallhauser emphasized the waxy bor-

der as a characteristic of all skin cancers, and gave a brief resume of the differential diagnosis between lupus, syphilis and skin cancer. He stated that the microscope was never necessary to enable the dermatologist to make a diagnosis, and differed with Dr. Ill regarding the curette test in a cheesy mass, stating that gummas and tb. may often give the same sensation. He advised against the use of arsenic in syphilitic luekoplakia, as many more carcinomas seen to develop under this treatment. He warned against smoking in syphilitic luekoplakia for the same reason. He felt that the dermatologists have done well in the treatment of skin cancers and reviewed the history of therapeutics in skin cancer, from the time when Maursden's paste was used through the tri-chloroacetic era down to the present, when radium is added to the acid treatment and very excellent results are obtained. He stated that as long as the epithelium grows up the condition is benign; when it grows down it is malignant. He felt, regarding the cause, that prolonged irritation with keratinization is the causative factor and infection is probably not concerned in the cause.

Dr. Baker stated that basal cell carcinoma is very easily treated with filtered rays.

Dr. Ill closing said that the hopefulness of carcinoma was the thing to emphasize in speaking to the laity, and quoted Dr. John G. Clark of Philadelphia who reports 30 per cent. cures after five years with all cases treated.

Academy of Medicine, Northern New Jersey.

A highly scientific, yet eminently practical paper of interest to all practitioners was presented by Dr. Henry B. Orton before the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey, at its December meeting. The title of the paper was "Observations on Eighty Cases of Foreign Bodies and Other Bronchoscopic and Aesophagoscopic Cases of Interest to the General Practitioner." The lantern slides of the x-ray of the eighty cases taken in the lateral as well as the anterior-posterior position was most instructive. Dr. Orton laid great stress upon the necessity of x-raying all cases of persistent cough, and the danger of attempting to remove foreign bodies from the larynx or aesophagus blindly.

United States Senator Royal S. Copeland, former Health Commissioner of New York City, in his address, "The Doctor and the Future," before the Academy of Medicine of Northern New Jersey, January 16, 1924, urged the medical profession to strive to have more physicians seeks Federal and State elective office. He stated that hygiene and all matters pertaining to the health of the people of the country is of first importance, to the government, as well as to the individual, and no one could better safeguard it, by wise legislation, than the trained doctor.

There is no committee on public health in the United States Senate. One could hardly believe it, if it did not come, from a member, of the Senate itself. When the countrywide medical diploma mills scandal was before the U. S. Senate for investigation, it was necessary to refer the matter to the Committee on La-

bor. Fortunately, Senator Copeland was appointed chairman of a sub-committee of the Committee on Labor, to carry on the investigation.

National Committee for Mental Hygiene.

Dr. Frankwood E. Williams was re-elected Medical Director of the National Committee at the annual meeting of the Board of Directors, held in New York City, on December 28. The following were elected members of the Executive Committee: Dr. William L. Russell, Medical Director, Bloomingdale Hospital, White Plains; Dr. Walter E. Fernald, Superintendent, Massachusetts School for the Feeble-minded, Waverly; Dr. Stephen P. Dugan, Director, Institute of International Education, New York City; Dr. William A. White, Superintendent, St. Elizabeth's Hospital, Washington, D. C.; Dr. Charles P. Emerson, Dean of the Medical School, University of Indiana, Indianapolis; Dr. C. Floyd Haviland, Chairman State Hospital Commission, Albany; Dr. Arthur H. Ruggles, Superintendent, Butler Hospital, Providence, R. I. and Mr. Matthew C. Fleming, Attorney, New York City. Dr. William H. Welch, President of the National Committee for Mental Hygiene, presided.

N. J. Mosquito Extermination Association.

This association will hold its annual meeting at the Hotel Traymore, Atlantic City on February 13, 14 and 15.

American Congress on Internal Medicine.

The eighth annual clinical session of the American Congress on Internal Medicine will be held in the amphitheatres, wards and laboratories of the various institutions concerned with medical teachings at St. Louis, Mo., beginning Monday, Feb. 18th, 1924. Practitioners and laboratory workers interested in the progress of scientific, clinical and research medicine are invited to take advantage of the opportunities afforded by this session. Address enquiries to the Secretary-General Dr. Frank Smithies, 1002 N. Dearborn Street, Chicago, Ill.

Hartford, Conn., Quack Probe.—The foreman of the grand jury charged with the investigation of medical fakers announced recently: "We have subpoenaed 100 doctors to disclose their status and explain to the grand jury how they obtained their medical diplomas and licenses. Many other witnesses, either patients of these doctors or surviving relatives and friends of deceased patients will testify." The State's attorney will consult with prosecutors and health officers from New York as well as Connecticut.

Tack Removed from Baby's Lung.—A St. Louis baby was sent to the University Hospital, Philadelphia, on funds provided by a St. Louis church to have a tack removed from the lung. The tack was three-quarters of an inch long was at the bottom of the left lung and was removed through a bronchoscope tube without injuring the membranes. Dr. Chevalier Jackson, professor of bronchoscopy, said the baby would probably be well enough to be taken home in a few days.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

1 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

HAS. D. BENNETT, M. D., Chm., 177 Clinton Avenue, Newark.

JOHN B. MORRISON, 97 Halsey St., Newark.

EDWARD J. ILL, M. D., 1002 Broad St., Newark.

DAVID C. ENGLISH, M. D., Editor, 65 Paterson Street, New Brunswick.

Each member of the State Society is entitled to receive copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to the EDITOR, New Brunswick.

The County Society Secretary shall send promptly to the Editor, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to the CHAIRMAN of the PUBLICATION COMMITTEE, Newark.

OUR ASSOCIATE EDITORS.

The Editor of the Journal as the result of much careful study as to the best method of increasing the value of our Journal in helpfulness to the members of our Society, suggested to the Board of Trustees and the Publication Committee the appointment of a few associate editors who would contribute editorial matter and select helpful articles on different subjects that would tend to increase our members' knowledge and efficiency in the practice of medicine and surgery. We are glad to report that our suggestion has received the unanimous approval of both the Trustees and Committee, and in consultation with them, the following have been appointed Associate Editors:

DR. CHRISTOPHER C. BELING, Newark.

DR. HARRISON S. MARTLAND, Newark.

DR. HENRY B. COSTILL, Trenton.

DR. JAMES HUNTER, Jr., Westville.

While their assistance will be most welcome in any part of the Journal's work, they have been asked to give special attention to the following phases of our profession's activities: Dr. Beling on Medical Defense and Industrial Insurance; Dr. Martland on Scientific Progress in our Profession; Dr. Costill on Needed Legislation for the Profession's and the

Public's Welfare; Dr. Hunter on the Work and Efficiency of County and Local Medical Societies in serving the Profession of the State and Nation.

We bespeak of them the hearty sympathy and co-operation of all our members in their endeavors to raise the standards and increase the efficiency of our profession in its efforts to serve the public in the prevention of disease and the relief of human suffering.

OUR COUNTY SOCIETIES.

The functioning of the County Society is in the last analysis the result of the activities of its various officers from the president down to the reporter. For this reason the County Societies should see to it at their annual meetings that they select from their membership only those who have the ability, those who are both willing and eager to carry out the duties of the office to which they have been elected. The willingness of the officers to do their part promptly, graciously and earnestly is what makes for the success of the local society. This applies especially to the office of secretary, which in the opinion of the writer is the real power house of every society. An active, energetic secretary is the dynamic force of each organization. He it is who gathers up the different lines of contact between the members and their interests in the medical life of their time, places them in their most effective attitude, and together with the other officers and committees of the society puts the Essay Committee to work to produce programs.

The president should be more than a mere figure-head. Tact, energy and the appreciative word should be his at all times in keeping the men up to the mark in both their ethics and professional work. He should at all times encourage the younger members of the society to produce good papers with more recent advances in medicine, as they have the advantage over the older men in their more recent schooling and laboratory technic. Listening to the younger men, the older members with their more extended experience are able to judge and advise as to the merits of the newer things in medicine, and thus act as a balance wheel to the over enthusiastic.

The reporter should be alive to his position, keen and prompt in all reports of the proceedings of his society, quick to take advantage of all ethical publicity that will advance the interests and reputation of the local society. He should have an innate

love of the work as well as the profession to stimulate him to always keep his local society to the front.

Not one half of the secretaries and treasurers forward their dues in time for the "Official Transactions," thus necessitating constant dunning upon the part of the Secretary of the State Society.

These things should not, and would not exist if the men elected to office were of the type who are willing, eager and anxious to serve the best interests of their local societies. It is the busy man who can always find the time for such duties, while the man with leisure is seldom on time with anything that he undertakes.

The honor, repute and eminence of the local society seldom rises above the character of the men who function as its officers. Therefore see to it that you elect those who serve *willingly, cheerfully and to their utmost* for the best interests of your county society.

James Hunter, Jr.

We call special attention to the above editorial of our Associate Editor, Dr. Hunter, on "Our County Societies." We are decidedly of the opinion that the greatest need of our profession is a more thorough organization of the County Societies and especially of better service on the part of their officers.

DR. KIPP'S MEMORIAL.

The Commemoration Day service in memory of Dr. Kipp, held in the Newark Eye and Ear Infirmary building on January 13th, was an occasion of far more than ordinary interest. There was a large attendance of doctors, business men and women. Dr. Eagleton, who is Dr. Kipp's successor as medical director of the Infirmary, presided, and gave an excellent report of the late Frederick Frelinghuysen's high estimate of Dr. Kipp's work. Bishop Lines' address was full of praise of the life and services of the deceased, and the other addresses were all highly commendatory.

Dr. Kipp was always an exceedingly busy man in private practice and in service in various hospitals and other benevolent institutions, but he was never too busy to forget his keen sense of duty—of advancing the standing and efficiency of our profession and the welfare of the public—through his attendance upon and contributions to the work of the meetings of our State Medical Society and other medical or-

ganizations. The younger members of our Society and those entering our profession should study his life and work and follow in his footsteps.

An account will be found of this meeting elsewhere.

IMPORTANT !!

Millions involved in School Health Program Bill for Public and Profession.

Assemblyman Hanson, at the request of the Committee on Health Problems in Education, has introduced a bill providing for the appointment of a "regularly licensed practitioner of medicine who has practiced five years in New Jersey" as Director of School Health. The duty of the Director would be to establish a Bureau of School Health in the State Department of Education and direct a School Health Program consisting of Medical Examination; Instruction in Hygiene; Physical Education; Habit Hygiene, Sanitation and School Nursing.

A member of the State Board of Health estimates that an effective program would be worth \$100,000,000 (one hundred million dollars) annually to the State and would result in a saving of life equivalent to 100,000 lives annually. The increase in professional work resulting from cases brought to light and cases enlightened is estimated at \$7,000,000 (seven million) per annum. These approximations designate the significance of the measure.

It is expected that the measure will have the backing of insurance, manufacturing and lay health organizations. It will probably be opposed by the associations of physical education, teachers who in 1917, while the profession was unaware, had a program of physical education set up instead of a program of health, one of their number now being a pseudo-director.

Every doctor should join the battle. Do we wish to be beaten by a crowd of "gym" people? Shall the people be allowed to suffer to enable one "gym" man to thwart public welfare? *Every doctor* should call upon or call up his legislators and urge the passage of the School Health Program Bill. *Every doctor* should urge his county superintendent to call the legislators likewise. *Every doctor* who examines for an insurance company should urge his agent to do likewise and to inform his superiors.

Every doctor should communicate with his leading manufacturers and urge them to support the School Health Program Bill because it means better safety.

Come doctors join the fight! The battle is on! Now is the time to show your colors! Take down the telephone! Drum *all* the influential people hard!—H. W. Haight.
(The proposed law will be found on the 1st page.—Editor.)

HEAR! HEAR!! THE TRUTH.

Editorial, N. Y. Times, January 13th.

When diploma-mill doctors deal death, the public is horrified. When genuine doctors ask for laws to protect the people from quacks and charlatans, a large and vocal part of the public sides with the get-degrees-quick imposters and take up their cry of bigotry monopoly and persecution. This is the history of medical legislation everywhere. And since legislators hear the voice of the people much more clearly than the voice of the expert, the diploma-mill "doctors" who lacks knowledge, training and professional honor continues to practice.

THEY ARE NOT DOCTORS

Editorial in the N. Y. Tribune

Since the chiropractors are in New York to stay, and their practices are tolerated, although some officials assert that they are open to prosecution, their status should be defined and they should be prevented so far as possible from treating patients under false pretenses. Proper licensing would at least drive out the thorough-going charlatans whom the bona fide chiropractor themselves disown.

As for the latter, if it is established that chiropractic is a useful form of treatment the Legislature should certainly forbid its practitioners to pose as a substitute for schools of medicine.

Mr. Homer Folks in a letter to The Tribune points out the danger of allowing chiropractors to call themselves doctors. They pass at present as "doctors of chiropractic." Their ambition is to be legally recognized on an equal footing with physicians, treating diseases with their panacea of spine adjustment. Mr. Folks suggests, perhaps playfully, that they may be permitted to be known as M. V.'s—manipulators of vertebrae. Certainly they should not be allowed to diagnose and heal by their manual applications the various types of disease. Their method has a very limited value; it is useless in many cases and positively harmful in others, in the judgment of physicians beyond suspicion of jealousy.

It will be difficult by any terms of licensing to keep the chiropractors from

gulling the credulous who accept their handling as a cure-all. But it may be better to make them pass a test before an impartial examining board and to send them forth not as "doctors," but simply as licensed chiropractors, than to permit all and sundry spine manipulators to pass as doctors, as they are doing now.

WHY NOT A BONUS FOR THE DOCTOR'S LABOR.

Each member of the Yankee ball team in 1923 got a cheque for \$6,160.46 as his share of the profits of the world's series. Each player on the beaten team (the Giants) got \$4,112.99 as his share of the profits of the world's series. These sums were in addition to the year's salary.

We do not begrudge the players this money—they earned it perhaps in providing amusement for the American public. The Doctor is engaged in saving human lives—his services are apparently not so much appreciated. We try to imagine how a doctor would feel if he got a bonus like the ones mentioned above at the end of his year's work, or indeed how he would feel to receive that much for his year's labor and no bonus at all.—Illinois Med. Jour.

COMPULSORY HEALTH INSURANCE.

Compulsory Health Insurance has broken down in Germany. England is next to complete breakdown under this false system of medical economics. We wonder what apology the several alleged leaders in this country now have to offer for their vigorous endeavor to have us following the footsteps of Germany and England. In several of the recent issues of the Journal we have published the details of the threatened strike of the panel doctors of England because of the insufficient compensation previously paid and the attempt of the government to again further reduce their already inadequate fees.

Recently fourteen thousand British "panel doctors" voted to go on strike January first. They not only complain about the proposed reduction of their pay from 9 shillings 6 pence a year per patient to 8 shillings 6 pence, but state they are dictated to by officials of the Health Ministry—none of whom are medical men—and the condition is intolerable.

Don't think that this issue is dead in America! It is still a live issue—fanatics and parlor socialists still are writing propaganda encouraging its immediate adoption.

and poor, misguided philanthropists are egging on unthinking legislators to do their dastardly work and get the bills through. They have been working quietly in the dark, while the good doctors of the country remain in blissful ignorance—feel that the old dragon is now comfortably dead.

We must awake! Shall we become, under a parsimonious government, the poorly paid slaves of a group of non-medical authorities, struggling with multitudinous, baffling forms to be made out? Or shall we fight, until the last drop of energy and brain-power has been expended in the battle?

—Illinois Med. Jour.

MEDICAL JOURNALISM.

Any State journal can be made better if the editor has the assistance and co-operation of the profession. Contributions can make it easier if they will take the trouble to have their articles not only typewritten but carefully edited as to grammatical construction, paragraphing, punctuation, and attention to clarity and conciseness of expression. Secretaries of county medical societies can help the *Journal*, as well as their organizations, if they will furnish condensed reports of the meetings of their respective organizations, together with abstracts of the more important papers. News notices, especially those relating to deaths, marriages, removals, and other occurrences of especial interest to the physicians of the State, must be obtained through officers of medical societies, individuals, or from the more uncertain news clipping bureaus. If these items could be sent in by those who are most familiar with them, it would add to the completeness of the *Journal*. Finally, the editor needs helpful assistance from those who can render it, and at all times he welcomes constructive criticism and suggestions to aid him in betterment of his work. It is presumed that the editor of each medical journal tries to produce a periodical which is a credit to him as well as to the association which he represents, and he will do his best when he knows that he has the encouragement and co-operation of the entire medical association, for that stimulates him to his best effort.—Editorial, Journal Indiana Medical Association.

As the *Journal* goes to press we hear of the death of Dr. George A. Rogers of Newark, on January 27th. Further notice will be given next month.

NON-PAYMENT OF DUES.

The name of no member of our Society whose dues for 1924 have not been paid will appear in the Official List of Members which is nearly ready for the printer. That means that former members not paying will not be regarded as in good standing in the County Society, the State Society or in the A. M. A.

MEMORIAL TO DR. KIPP.

In commemoration of the death January 13, 1910, of Dr. Charles J. Kipp, a large group of his friends and professional associates gathered at the Newark Eye and Ear Infirmary recently and heard several speakers pay tributes to his memory. Dr. Kipp was founder of the infirmary 43 years ago.

The gathering was arranged by Dr. Wells P. Eagleton, medical director of the infirmary, on behalf of the trustees.

The eulogists included Dr. Eagleton, who presided; Mayor Breidenbach, representing the Newark City Hospital; Bishop Lines, representing St. Barnaba's Hospital; Dr. Edward J. Ill, representing St. Michael's Hospital; Mrs. George Barker, president of the board of managers of the Babies' Hospital; Dr. Fred Hughes, president of the board of managers of the State Sanatorium for Tubercular Diseases at Mt. Kipp, Glen Gardner, and Dr. David C. English, editor of the *Journal of the Medical Society of New Jersey*. In all these institutions Dr. Kipp had been active in their formation, development or management.

By way of introduction, Dr. Eagleton said: "When a man leaves to a community at his death an inheritance of noble and constructive work, it seems fitting that the beneficiaries should bear it in memory and gather to express anew their remembrance and appreciation."

That, the speaker said, explained the assembling of friends and associates of Dr. Kipp on the thirteenth anniversary of his death. Continuing Dr. Eagleton said: "This institution was founded by Dr. Kipp with the assistance of a group of men, conspicuous among whom were William Clark, Sr., Robert F. Ballentine, and Frederick Frelinghuysen. The latter has been treasurer from the founding of the infirmary until his death recently. In the minutes of the board of trustees Mr. Frelinghuysen wrote the following:

"This institution was founded in 1880 through the instrumentality of Dr. Kipp, and he brought with him a body of personal friends who undertook the work because they were assured of being associated in a beneficial work with a man pre-eminently qualified by his magnificent ability. No greater monument to these abilities could be raised than the immense work the institution has done for so many years. It was Dr. Kipp's personality which drew the founders of this institution about him as well as always called the skilled and learned in his profession to labor with him. The hundreds and thousands who have

been healed by his hand bear testimony to his untiring skill. To the sacrifice of his own personal and remunerative practice he gave his best to the amelioration of mankind with simplicity and without ostentation, and with an ability which stood in the front rank in this country and in foreign countries. We are fortunate to have had him for a friend and associate, and to have been permitted to some degree to have helped in his work. We will cherish his memory and in no way can we do this so well as to sustain the great work of this institution to which he devoted his life."

The Rt. Rev. E. S. Lines, Bishop of the Diocese of Newark, spoke handsomely of Dr. Kipp's life and services, especially in the work of St. Barnaba's Hospital.

He was followed by Dr. Edward J. Ill, representing St. Michael's Hospital; Mrs. George Barker, representing the Babies' Hospital; Dr. Fred. Hughes, representing the State Sanatorium, Glen Gardner (Mt. Kipp); Dr. David C. English, representing the Medical Society of New Jersey. These were all highly eulogistic of the man and his work.

Dr. English at the conclusion of the meeting distributed a brief sketch of the memorial services held at the annual meeting of the State Society in 1911, which he had had printed with a picture of Dr. Kipp. It gave the action of the State Society Board of Trustees and the editorial in the Journal.

PROPOSED SCHOOL HEALTH LAW.

A Supplement to an act entitled "An act to establish a thorough and efficient system of free public schools and to provide for the maintenance, support and management thereof," approved October nineteenth, one thousand nine hundred and three.

BE IT ENACTED BY THE SENATE AND GENERAL ASSEMBLY OF THE STATE OF NEW JERSEY:

1. The Commissioner of Education shall by and with the advice and consent of the State Board of Education appoint a Director of School Health, who shall hold office for a term of five years and shall receive an annual salary of nine thousand dollars and an allowance for expenses not to exceed annually the sum of fifteen hundred dollars.

2. The director whose appointment is provided for by this act shall at the time of his appointment be a regularly licensed physician of this State, who has been actively engaged in the practice of his profession in New Jersey for at least five years preceding his appointment. Such director shall devote his entire time to the duties of his office.

3. The duties of such Director of School Health shall be to direct, set standards, and supervise medical inspection together with all activities related thereto in all the school districts of the State, and further to direct, set standards, and supervise instruction in the public schools in physical training, personal and community health and safety, domestic hygiene, first aid and nursing and all other activities prescribed in the physical training course as outlined in Chapter 107 of the Laws of 1917. The expert assistants appointed by the Commissioner of Education in pursuance of Chapter 107 of the Laws of 1917 to carry

out the provisions of the Physical Training Law shall act under the general direction and supervision of the Director of Medical Inspection and Health, who shall in turn perform his duties under the general direction and supervision of the Commissioner of Education and the State Board of Education.

4. For the purpose of enabling the Commissioner of Education and the State Board of Education to carry out the provisions of this act there shall be appropriated in the annual appropriation bill the sum of ten thousand five hundred dollars, which sum shall be in addition to the annual appropriation to carry out the provisions of the Physical Training Law as provided for in Chapter 107 of the Laws of 1917.

5. This act shall take effect immediately.

STATEMENT.

The purpose of this bill is to secure an efficient program in the public schools by co-ordinating all school health activities under a Director of Medical Inspection and Health, who shall be a competent physician and shall be appointed by the Commissioner of Education and the State Board of Education at an annual salary of \$9,000 with an allowance for expenses not to exceed \$1,500.

Welfare Committee Meeting.

A meeting of the Welfare Committee, Medical Society of New Jersey, was held at the Stacy-Trent Hotel, Trenton, on January 5th.

Present were: Wells P. Eagleton, M.D., Essex County, President of the State Society and Chairman of the Welfare Committee; Alexander MacAlliser, M.D., Camden County; A. Haines Lippincott, M.D., Camden County; Frederick J. Quigley, M.D., Hudson County; John B. Morrison, M.D., Essex County; W. G. Schauflier, M.D. and Henry B. Costill, M.D., Mercer County; Richard M. A. Davis, M.D. and David M. Green, M.D., Salem County; Launcelot Ely, M.D., Somerset County; James Hunter, Jr., M.D., Gloucester County; Arthur B. Smith, M.D., Middlesex County.

Dr. Quigley read a communication from Mr. Wall, counsel to the State Society, with reference to a law defining the use of the title "Dr." and "M.D." and declaring that the present law, in his opinion, was sufficient for prosecution for the use of these titles by persons not medical doctors, despite the opinion of the Attorney General to the contrary. After a lengthy discussion a motion was offered by Dr. Costill and passed to the effect that a committee be named from among the members of the Welfare Committee to take up the question with the Attorney General for the purpose of enforcement, and if the present law is not strong enough to prepare a new bill for presentation to the legislature under which prosecutions could be made. Dr. Costill, Dr. Hunter and Dr. Schauflier were named the committee.

Dr. Quigley said that physicians from foreign countries are coming into New Jersey in numbers, and suggested that they become U. S. citizens or at least take out first naturalization papers before they are granted a license to practice medicine in this State. After a general discussion the matter was referred to the annual meeting of the State

Medical Society on motion by Dr. Ely, seconded by Dr. Lippincott.

Dr. Eagleton read a statement to the public press, with regard to the publication of damage suits against physicians and to manufacturers and insurance carriers, urging that the family physician be employed as much as possible in workmen's compensation cases. Both statements were approved by the committee, and it was directed that they be sent to every manufacturer and insurance carrier in the State and the press statement to every newspaper in the State.

The copy of the amendment to the venereal disease control, act, submitted by Dr. Lippincott, was adopted as the bill which the committee would submit to the legislature. The marriage certificate bill was presented, discussed and approved for presentation to the legislature by the Welfare Committee.

Bills amounting to \$84.98 were approved.

Dr. Eagleton announced memorial exercises to be held at the Newark Eye and Ear Infirmary on Sunday afternoon, January 13, in memory of Dr. Charles Kipp, the founder of the institution, and extended an invitation to the members of the committee to attend.

Dr. MacAllister presented copies of three bills which the State Board of Medical Examiners had prepared for introduction into the legislature. They provided for the licensing by the Board of Medical Examiners of schools or colleges teaching healing in New Jersey; the licensening of hospital internes and the certification of records of the board for court cases. On motion the consideration of these bills were made the special order of business of the committee at a special meeting called for the State House, Trenton, January 14, at 8 P. M.—Joseph H. Gunn, Exec. Sec.

Statement to the Public Press.

January 17, 1924.

The Medical Society of New Jersey endeavors to protect its members from the unjust practice of individuals who have instituted "strike" malpractice damage suits against physicians. In no instance has the Medical Society protected, or will it protect, any physician who has been guilty of negligence, dishonesty or incompetence, much less violation of law. In some instances during the past few years suits have been brought against members of this society where there has not been the remotest chance of obtaining a verdict. These suits have been instituted by individuals, with the assistance of those members of the bar who place pecuniary advantage above ethical consideration, with the idea that the physicians, to avoid publicity of such action, would settle out of court.

This method too frequently has been simply a disguised form of blackmail, to check which the Medical Society of New Jersey organized a Defense Council, who after hearing the physician's side of the case, if they regard him guiltless, order the case defended. In the past two years out of suits aggregating \$400,000, not a single dollar has been collected by law. In every case that has been defended by the State Society the verdict has been in favor of the physician.

On the face of this record we are asking the

press of the State to co-operate with us to help to stamp out the unfair practice of "strike" suits. The medical profession requests the press to refuse to publish an account of any suit until its actual trial in courts. Whatever verdict is rendered by court or jury, the facts should be published, but "news stories" or suits which are simply "strikes" are detrimental to the morals of the community as well as to the physician attacked, as those who institute "strike" suits use news publicity, although at the time they may know that the physician is absolutely innocent of wrong; they seek a financial settlement without carrying the case to trial. Without the publicity from the newspapers, there would be very few "strike" suits.

"The Passaic Daily News" has announced a policy of publishing nothing about a damage suit against a physician until the suit is terminated in court. This policy is one which the medical profession would respectfully request be adopted by all newspapers, and is asking for your co-operation by adopting a similar policy for your paper in the interest of public morality, as well as for the protection of the members of the medical profession. After consideration will you kindly inform us whether your paper will adopt such a policy?

Signed,

Welfare Committee,

Wells P. Eagleton, M.D., Chairman

and President of the Medical Society of New Jersey.

Signed also by other members of the Welfare Committee.

ONLY ONE BOARD IS NEEDED.

From the New York Times.

In no State should there be more than one medical examining board, and that one alone should issue licenses to practice medicine. Its members would not belong to any "school." They would be men of real medical education themselves, able to distinguish between a real college and a diploma mill—between a real doctor and a quack. They would know that a real doctor is one who has acquired a decent knowledge of all the many means by which disease, by himself or others, can be prevented and cured if curable. They will be ready to use suggestions or the manipulation of bones or viscera in cases demanding it—as ready as they are to administer drugs when drugs are needed or trust wholly to diet and outdoor life in the not infrequent instances when nothing more is required or can be done with any expectation of benefit.

Not one of the men licensed by such a board would claim universal efficacy for any form of treatment. Whoever does that is instantly revealed as a quack, either ignorant or dishonest, and he is not any the less a quack because he can produce "testimonials" from grateful patients, including the familiar legislator whose close relative was saved from fast-approaching death by an "irregular" after he, where from one to a dozen "regular" doctors, or more often she, had been given up by any.

The number of people, otherwise intelligent, who can thus be deceived and with the best of intentions can deceive as gullible as themselves is disgracefully humiliatingly large.

Hospitals; Sanatorium.

Cooper Hospital, Camden, Free Beds.—Mrs. A. M. Marshall, Woodbury, Gloucester County says: "I will give \$5,000 to endow one free bed in a ward of Cooper Hospital, Camden, provided the 10,626 pupils of the public schools of Gloucester County will raise and give \$5,000 to endow one free bed in a ward of Cooper Hospital during the year 1924."

Dover Hospital.—The financial needs of the Dover General Hospital were recently discussed by Drs. J. Willard Farrow and W. F. Costello, and others before the Kiwanis Club, when the Kiwanians instructed its public welfare committee to organize a campaign to raise funds, in union with several other fraternal organizations, to provide an endowment for the hospital.

Dr. Farrow, a member of the hospital staff, said there were 539 patients admitted to the institution during 1923, 283 of them for operations. About forty-four per cent. of the patients, he said, received treatment free. The number of deaths for the year was thirty-three, or 6.1 per cent. of the total number of patients. One of the great needs, he said, is a maternity and children's ward.

Monmouth Memorial Hospital.—The board of governors of this hospital recently approved the move to endow a bed in the surgical ward in memory of Dr. Edwin Field of Red Bank, chief of staff at the hospital for more than twenty-five years. It is proposed to raise the \$5,000 needed by popular subscription.

Muhlenberg Hospital, Plainfield.—The endowment fund at this hospital has reached \$381,500.

Somerset Hospital.—This hospital at Somerville is one of the three hospital residuary legatees under the will of James A. Lowe of North Branch, the other hospitals being St. Vincent's and St. Luke's of New York.

St. Peter's Hospital, New Brunswick.—The board of directors of this hospital will begin a county-wide campaign for \$300,000 in April. The present building in spite of numerous additions has been outgrown.

The building will be erected on the present site of St. Mary's Orphanage, in Easton Avenue. The structure, it is estimated, will cost more than \$5,000,000. The present staff, including fifty-one physicians, eighteen sisters, seventeen graduate nurses and twenty-six pupil nurses, cared for more than 4,050 patients last year. In its first year of operation, in 1908, the institution cared for 386 patients. In its sixteen years' work 14,815 patients were cared for who made no financial return and 16,436 paid in part or full. Persons from nearly every State in the Union are listed in the records, a large number being received as the result of motor accidents. The new structure will be of brick and white stone and will contain 150 beds, an increase of fifty over the number available in the present building.

Verona Sanatorium's Needs.—Verona Sanatorium took better care of its tubercular patients last year than ever before, yet cut the cost of doing it. It increased its overhead by adding necessary equipment and doubling employees' pay, yet returned to the county more than \$40,000 out of its appropriation of \$325,000. It asks, through the freeholder committee in charge, for \$10,000 less this year than last, yet plans to progress in efficiency and results. Verona has 250 beds. They are always full, but the average stay of patients is only three months. They go out cured as to the majority, to stay cured if they follow a proper regimen. There is a waiting list of thirty-five, but it does not represent anything like the number who should have the benefits of sanatorial care. That move them as sources of infection. Those who seek maximum results from Verona speak of the need of 100 more beds.

Deaths.

HOLT.—In Peking, China, January 14, 1924, Dr. Luther Emmett Holt, Professor in the Rockefeller Institute. Dr. Holt was one of the leading child specialists in the world, and a ranking man in pediatrics. He went to Peking with Mrs. Holt several months ago to give a series of lectures at Union Medical College.

UNDERWOOD.—In Newark, N. J., January 17, 1924, Mrs. Elizabeth Paterson Belcher Underwood, wife of Dr. Chas. F. Underwood

Public Health Items.

Summit Health Report.—The death rate of 8.27 per 1,000 in 1923 was the lowest in the history of the city. The birth rate was 23. No deaths occurred from communicable diseases, of which 365 were reported, less than any year for the last five years. Deaths under one year numbered fourteen.

New Jersey Death Rate in November.—Deaths in New Jersey reported to the Bureau of Vital Statistics during November totaled 3,212, including fifty-seven non-residents, representing a rate for the month of 11.12, as compared with 11.01 for October and 9.50 for September. A noticeable increase is shown in deaths from typhoid fever, measles and pneumonia, with other classified causes of death showing about the average for this period of the year. There were 408 deaths of children under one year, 141 deaths of children more than one year and under five years, and 1,252 deaths of persons sixty years or more. There were forty suicides during November, as compared with the average for the previous twelve months of thirty-eight.

U. S. Death Rate, 1922.—The Department of Commerce recently announced that 1,101,863 deaths occurred in 1922 within the death registration area of continental United States, representing a death rate of 11.8 per 1,000 population as compared with the record low rate of 11.8 in 1921. The area in 1922 com-

prised 35.3 per cent. of the estimated population. The increase in the rate from influenza and pneumonia (all forms) from 99.8 per 100,000 population in 1921 to 133.5 in 1922 more than accounts for the slight increase in the rate from all causes. Some of the other diseases for which the rates increased are cancer, diabetes, diseases of the heart, nephritis and cerebral hemorrhage. Tuberculosis (all forms), typhoid fever, scarlet fever all showed decreases.

Scarlet Fever at Westmont.—Fear of recurrence of an epidemic of scarlet fever caused authorities of Haddon township recently to order public schools at Westmont closed. An epidemic of scarlet fever developed in the section a year ago, and caused the closing down of the schools for a long period.

Health Education and Community Uplift.—If I had the problem of elevating the general moral and mental tone of a backward community I would seek the services of the public health worker, the sanitarian and the personal physician even before those of the teacher. Health education must go forward hand in hand with that of the mind.—Ray Lyman Wilbur, Stanford University, Calif.

Delay in Using Diphtheria Antitoxin.—A large percentage of the deaths from diphtheria which occurred during the last year in New York State might have been prevented had proper administration of antitoxin taken place immediately, according to Dr. Bertrand H. Roberts, epidemiologist of the State Department of Health.

Delay in administering such a preventive is laid by Dr. Roberts to the carelessness of parents or guardians for the most part, although he does not absolve the attending physicians from entire blame. The latter, he declares, in many instances failed to give specific treatment. He said it is unjustifiable to delay treatment while awaiting a laboratory report on a culture if there is even a suspicion that the patient may be suffering from diphtheria, for even if one could obtain an immediate report, it is never safe to rely upon it to disprove the diagnosis.

Measles Germ Found?—The discovery of a heretofore unknown microbe in the blood of measles patients is announced by Drs. Salimbeni and Kermorgan. It is of the spirochaeta species, corkscrew shape, and always appears in the presence of another species of bacteria, without which it seems to be unable to live. The discoverers are continuing their research work, believing the microbe may prove to be the cause of measles.

Septic Infections Following Childbirth.—Dr. Edgar a Vander Veer, Albany, N. Y., at the annual meeting of the Amer. Ass'n of Obstetricians, Gynecologists and Abdominal Surgeons, said: Midwives, so far as statistics are available, seem to make a better showing than the ordinary practitioner, which may be explained in two ways: 1. The general practitioner is usually in a hurry when attending a confinement case, and makes frequent and

unnecessary vaginal examinations, with the resultant increase of the chances of infection. The midwife is content to sit patiently by and let Nature perform her part, making few examinations, and consequently with a good deal less chance of infecting the woman in labor. 2. The midwife, in a great majority of the cases, attends only the normal confinement, sending of the physician whenever anything abnormal occurs, with the result that if anything goes wrong the physician is charged on the records with the maternal death, and not the midwife, to whom, in many cases, it should be attributed, thus apparently giving the midwife a better record than she should have, and the physician a poorer one. I believe there should be a classification in which both the midwife and the physician are in attendance and sharing the responsibility. In 1910, the maternal mortality rate, outside New York City, from all puerperal causes, was 78 per cent.; in New York City it was 66 per cent. The mortality rate for puerperal septicemia was 28 and 18 per cent., respectively. The maternal death rate, from all puerperal causes, gradually dropped to 1916, when it was 54 per cent. and 46 per cent., respectively. The death rate from puerperal septicemia dropped to about 29 per cent. and 18 per cent., at about which it has remained ever since, showing some improvement in that direction. In 1917 the maternal death rate from all puerperal causes gradually rose again, reaching its peak in 1918, when it was 82 per cent. and 70 per cent., respectively. This increase in the death rate was due to the influenza epidemic and possibly also to the inability for the woman in labor in the rural district to receive proper medical attendance, so many physicians being away in service. That year the mortality rate from puerperal septicemia remained about the same. For 1921 the mortality rate from all puerperal causes was 60 per cent. outside New York City, and 54 per cent in New York City.

Personal Notes.

Dr. David E. English, Summit, after many years' service as physician of the Arthur Home for Blind Babies in that city has resigned and Dr. H. P. Dengler, Springfield, has been appointed his successor. Dr. English gave his services without charge, visiting the home every day and taking more than a professional interest in his little charges. He was always remembered at Christmas time by the children. He and Mrs. English will go to Florida in a few weeks and later they may go to Georgia.

Dr. Ernest W. Mierau, Irvington, has been appointed health officer of that town. He is also police surgeon.

Dr. Joseph G. Coleman, Sussex, was recently installed Worshipful Master of the Samaritan Lodge, F. and A. M. of that town.

Dr. John C. Loper, Bridgeton, medical inspector of schools reports that out of the thousands of pupils vaccinated their has not been one serious result. It is stated that there have been forty cases of smallpox in South Jersey the past few months.

Journal of The Medical Society of New Jersey

Published on

the First Day of Every Month



Under the Direction
of the Committee on Publication

Vol. XXI, No. 3

ORANGE, N. J., MAR., 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

THE TREATMENT OF SINUSITIS*

By **E. Ross Faulkner, M.D.,**
New York City.

I feel that I must apologize for offering you such a worn out subject, yet the great variety of opinions which are maintained and taught would seem to justify the attempt to formulate the best methods in vogue at the present time.

No method of treatment can long hold very much support which is not based on a proper recognition of the underlying pathological conditions which prevail, and all treatment of diseased tissue anywhere, should aim to assist nature in restoring parts which have undergone a pathological change, back to normal, physiological function.

We can never make a more profitable study than to read again and again, the classic article on "Inflammation," which was written by Adami, and published in most textbooks many years ago. Let us then consider for a moment the early phenomena of an inflammatory process and their attending results, and then adapt our rationale of treatment to the anatomical parts.

As we know, Nature's first effort is to bring a greatly increased blood supply to the parts affected. This army of defense may be too impetuous in its first onslaught, and so its effects have to be controlled.—hence we apply cold to prevent too much swelling, which is liable to choke the circulation but in inaccessible parts—such as the accessory sinuses—we must resort to other means. Now we know that certain drugs will act in quieting this turbulent vascular change, and chief among these are opium and belladonna. There was nothing

better than the old coryza tablet in the early stage of an acute sinusitis. Since they are no longer easily obtained, I usually prescribe:

"Dover's	grs. III.
Phenacetin	grs. III.
Camphor	grs. $\frac{1}{2}$
Caffeine	gr. I."

Every four hours.

I cannot believe that any local application or irrigation is advisable in the first forty-eight hours. The exercise of some vascular control is more imperative in this region than in most parts of the body for the reason that unless swelling is limited, severe pains ensue. In addition, the swelling causes complete blockage of drainage from spaces which will soon become filled with fluid, and initiating a vicious cycle, the fluid becomes retained under pressure, and adds to the pain and absorption.

Following on to our second stage of inflammation, we have a stagnation of the vessels, with swollen waterlogged tissues, and here measure must be taken to stimulate the circulation and absorb the exudate. Hot application are now most efficacious on all accessible parts, and this can be carried out to some extent in the nose by hot saline irrigations, following this with some mild astringent antiseptic, such as freshly prepared warm argyrol. The best method of applying this is by means of the post-nasal douche. Under such treatment resolution may occur in a few days.

If however, the inflammatory process has gone a little further, the exudate will take on a purulent character. Here the previous outline of treatment by irrigation and astringents should be carried out. This reduces the swollen membrane about the orifice of the various sinus openings, and facilitates drainage. The warm saline also stimulates the action of the cilia, which move the secretion toward the openings. In

*Read at the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey, February 16th, 1923.

the ordinary nose this treatment will be effective in over 90% of cases. But if the anatomical condition of the nose is bad, this treatment cannot be effectively carried out, and if the discharge is continuing beyond a period of four or five weeks, measures should be taken to correct the anatomy,—such as a submucous operation or a partial turbinectomy.

Failing to effect a cure by treatment in three or four weeks after this has been done, I believe one is justified in further operations to promote drainage of the sinuses. No one would think of leaving a subacute mastoid to pass into a state of chronic suppuration, and I don't believe that any case of suppuration in the nasal sinuses which has not yielded to proper treatment, should be left unoperated on beyond a period of six weeks or two months. Operations in the acute stage are contraindicated, but, if at the end of a week or ten days there is no amelioration of the symptoms, and drainage is badly blocked, one might justifiably do a limited submucous, or turbinectomy, or puncture an antrum or sphenoid. In cases of very acute antrum, ethmoid, and frontal sinusitis with marked swelling externally, one should do everything to promote interansal drainage. The swelling externally is no indication to operate unless there is marked exophthalmus, and fixation of the eyeball indicating that there has been rupture of the ethmoidal cells into the orbit. Even in these cases one does not have to rush into an external operation if there is any evidence of intranasal drainage. If the optic nerve is showing signs of neuritis in an acute case, it will be necessary to open the posterior ethmoids and sphenoid without delay.

The general treatment in all acute conditions should be rest in bed with good air and good food, and this should be continued till complete recovery. There is no doubt that patients get up an immunity far quicker while at rest than they do if allowed to remain active.

Let us now consider the further stage of our inflammatory phenomena, whose end results are caries or ulceration, persistent suppuration, necrosis, and sclerosis of fibrosis. With these results inflammation passes into the chronic stage.

In caries or ulceration in the sinuses, we have a destruction of mucous membrane, usually with some molecular destruction of bone. Where such a process exists in accessible regions, cleanliness with control of

granulations is sufficient to allow Nature to carry on the healing process, but in the sinuses where such areas are kept bathed in pus, exuberant granulations soon form with resultant formation of polypi, and it becomes necessary to scrape these away with the underlying diseased tissue. This in the ethmoid region, will mean the complete extirpation of the cells to leave one cavity, which can be subsequently treated as a proper surgical field and kept clean. In chronic suppuration, after all methods of treatment have failed, operative measures should be undertaken to promote free drainage in every sinus involved. Necrosis as an end result of inflammation is exceedingly rare. I have seen four cases of necrosis of a considerable portion of the superior maxilla in children as a result of, or associated with acute antrum disease, but have never seen such a result in adults. This should be treated the same as necrosis anywhere else,—that is provide drainage for the pus and remove the sequestrum after Nature has separated it. This separation takes place very quickly in a vascular bone like the superior maxilla.

Fibrosis or sclerosis as an end result of inflammation of sinuses may occur in either the soft parts or the bone. When occurring in the soft parts alone, it is usually due to a low grade irritant in a nose with poor drainage, or in some instances it undoubtedly may be due to an irritant conveyed to the part by the blood stream, or from the air, hence the treatment consists in regulating the diet, and eliminating all contact with sensitizing proteins, and if necessary providing better drainage for the nasal cavities. Sclerosis of the bone, on the other hand, in its most marked form, is due to an old suppurative process which has usually begun in childhood. Granulation tissue has formed, and undergone ossification, and a gradual obliteration of the sinuses has occurred. With this sclerosis of the bone, the mucous membrane undergoes an atrophic change, and when the mucous glands have finally lost their function, what secretion of pus remains, dries up in situ, and ozaena results. Nature sometimes effects a cure in these cases by a complete filling in of the spaces. An analagous process goes on in the mastoid cells as an end result of a suppurative process. I have met several cases in the cadaver of a most complete obliteration of the antra in this way.

Treatment in these cases is very unsatisfactory except in young subjects before an

advanced sclerosis has taken place. In young subjects, an intranasal sinus operation with persistent after-treatment will produce satisfactory results. In older subjects, one can accomplish very little by attempting an operation on the ethmoids. Opening the antrum however, will always be worth while, and may entirely relieve the ozoena. As these cases usually have started in childhood, one often finds that the process of development of the sinuses has become arrested so that many of them have no frontals, and but very small sphenoids. This somewhat simplifies operative procedure if the condition offer any promise that such an effort may be successful.

Having now outlined the various forms I will endeavor to formulate in concrete of treatment based on pathological changes, form the conditions which make operation on the sinuses advisable:

1. Cases with profuse, purulent discharge, which will not clear up on treatment.
2. Case with polypi causing nasal obstruction, with or without asthmatic symptoms.
3. Cases of ozoena in young subjects.
4. Cases with pus in the sinuses causing manifestations of focal infection.
5. Cases with involment of adjacent structures.—such as optic nerves 3rd, 4th, or 6th.
6. Certain acute cases which have ruptured into the orbit, or externally.

THE RECOGNITION OF EARLY PULMONARY TUBERCULOSIS*

By George H. Lathrope, M.D.,

Attending Physician to the Memorial Hospital, Morristown, Consulting Physician to the Dover General Hospital, and to All Souls' Hospital, Morristown.

Early tuberculosis of the lung is a condition rarely susceptible of exact proof. The diagnosis in the majority of cases should be made on reasonable suspicion and while reasonable suspicion is aroused, and many cases treated as such, far more frequently than was the case even fifteen years ago, there is yet so considerable a number which go unrecognized till the disease is fairly well advanced, that it seems worth while to review the criteria upon which a reasonable tentative diagnosis of tuberculosis may be fairly based.

*President's Address at the Annual Meeting of the Morris County Medical Society, September 11th, 1923.

This function should be assumed more largely by the general practitioner. It is really his province. The pulmonary specialist should be sought by him mainly to corroborate his findings and aid in determining how the patient should be treated. One of the greatest stumbling blocks in the way of early recognition of this disease is the frequent unwillingness on the part of both the patient and his family physician to face unpleasant facts. Present discomforts are given more weight than future dangers; and too often, when finally induced to accept the fact, the patient has sinned away his day of grace.

On the part of the physician, feelings are sometimes allowed to gain the better of his judgment and he yields to the temptation to avoid unpleasant statements to an unsuspecting patient; and this unfortunate attitude provokes delay in the proper treatment, and wipes out the margin of safety for a patient who, if firmly dealt with early enough, would have every reasonable prospect of cure.

The diagnostic criteria of pulmonary tuberculosis may be grouped under four heads:

1. Clinical history; 2. Laboratory evidence; 3. Roentgenological evidence; 4. Physical signs.

1. We occasionally encounter a patient who gives a history of symptoms for only a short time, two or three weeks perhaps. He "caught cold," cough and expectoration ensue, low grade fever persists, and there is a malaise out of proportion to an ordinary bronchial or tracheal cold. On examination, definite signs are found in the chest, tubercle bacilli are present in the sputum, and x-ray evidence is positive, and so the diagnosis is established. In the first place, I believe this type of history is not usual; and in the second, that most of these patients are poor observers, and that a careful inquiry will elicit a history of preceding malaise, loss of weight, fever, or digestive disturbances, to which the patient has paid little or no attention.

The more usual thing is a history of ever increasing fatigue, mild loss of appetite, vague to marked disturbances of digestion, loss of weight over a period of several months, dry hacking cough in the morning, with the development finally of a small amount of sputum which comes definitely from the trachea; perhaps even chilly feelings in the afternoon or the observation of a P. M. temperature of 99.5 or 100. Singly,

or in any combination, such symptoms should arouse at once a careful inquiry; but are too often dubbed malaria and treated with tonic doses of quinine, to the detriment of the patient's health and prospects of recovery.

Hemoptysis may be the sole symptom, and the patient may strenuously deny any other evidence of ill health. Of course, the gums and nasal passages must be excluded as a source. Personally I have never seen a case where it was proven satisfactorily that the source was in the throat. If that were at all common, we should have more reports from the throat specialists as to locating such bleeding points—a procedure which to them should present no great difficulty, and I would like to hear them discuss the subject and state frankly just how often they have been able to locate such a focus of hemorrhage in the pharynx or larynx. If blood is coughed up, in ninety-nine times out of a hundred, its origin is below the vocal cords; and if it does come from that area, the burden of proof is certainly on the man who says it is not from a tubercular lesion. In this connection we know that in the great influenza epidemic 1918-1919, frank hemoptysis was a frequent occurrence amongst the pneumonia cases. We had here a combined influenza bacillus and hemolytic streptococcus infection of great severity. It is just possible that we may meet occasionally with a low grade variety of this same condition which gives rise to hemoptysis as a symptom. I think however, that as a practical working diagnosis, it is both difficult and dangerous, and again must reiterate that the burden of definite proof is on the man who says that a given hemoptysis is not due to tuberculosis.

Aside from hemoptysis, a history of malaise, mild anorexia, indigestion, loss of weight, with or without cough and expectoration, should provoke a careful search with pulmonary tuberculosis in mind; and if no other good and sufficient reason be assigned for the patient's symptoms, a pulmonary lesion must be carefully sought and, if possible, excluded. Temperature and pulse observation are invaluable, and should be made at least three times a day and recorded. Any temperature irregularity—i. e., a daily excursion of a degree or more—should be viewed with suspicion; and a pulse rate above 90 in men or 96 in women should be a cause of inquiry.

2. Laboratory evidence is sometimes obtained early. Sputum examination should be done where possible, and if negative done repeatedly until one is thoroughly satisfied that tubercle bacilli are not to be found; but ultimate failure to find tubercle bacilli does not in any sense negative a diagnosis which can be reasonably assumed from other signs and symptoms. A secondary anemia often comes on in tuberculosis fairly early, and is a valuable finding—so that I think a complete blood count should always be done.

As to Arneth's differential polynuclear count in tuberculosis, I can say very little or nothing from practical experience; but the work of Ringer and Minor has shown that it is uncertain, and has little or no bearing on early tuberculosis.

The complement fixation of the blood, which at one time promised much, has met with so many stumbling blocks that, in its present state, it has been abandoned by the Saranac Laboratory which was, and still is, working on it. The test may be perfected some time in the future, and, if it becomes available, will be a valuable aid.

Tuberculin reactions are of service in young children, but to no great extent in adults, and should not be relied upon to the exclusion of other methods of diagnosis.

3. The stereoscopic roentgenogram and the fluoroscope should be employed as one uses his stethoscope, and regarded as valuable aids, but as in no sense exact instruments of diagnosis.

The real question here is not so much the presence or absence of evidence of tuberculosis as of evidence of activity. We should never allow the x-ray man to make the diagnosis of tuberculosis for us to the exclusion of our own judgment in the matter. He gives highly valuable aid; but it must be carefully correlated, in these early cases particularly, with symptoms and physical signs. A very considerable number of adults show pulmonary shadows on x-ray examination which can be interpreted as tubercular, and the question of activity or inactivity is all important. The roentgenologist's opinion on this point is valuable, but most emphatically should not be accepted to the exclusion of other diagnostic methods.

4. The subject of physical signs might be gone into at some length and much said about various types of rales—about varying degrees of relative dullness, and about this and that change in voice and breath sounds;

but I am talking to you from my own every day experience which, I take it, is not very different from yours, and I frankly admit that in the majority of cases where I find physical signs, the condition must be interpreted as having gone beyond the early stages. Therefore, for this particular phase of the problem, I have placed physical signs as last in the order of importance of the four criteria for establishing an early diagnosis of tuberculosis of the lungs.

At that I would not pass over what I believe to be the fact that sometimes a constant collection of rales may be found in early cases; and if these are constant, if they are unilateral, if they are located in the upper half of the chest, they are of distinct value; but the suspicion is at once aroused that the case may not be altogether an early one. My reason for taking this position is that in reading chest plates during the past six years the conviction has grown that most of the time the tubercular process starts at or near the roots of the lung, and spreads thence toward the periphery. Thus, in its early stages, it may be too deep to obtain signs from percussion or auscultation.

Pottenger claims that rigidity of the costal muscles is a very early sign.

The theoretical argument for a protective reaction in the muscles for an underlying lesion has its best analogue in abdominal conditions, but the practical problem of eliciting the sign seems to me very great. The muscles are narrow and lie between closely placed ribs, and there is nothing like the freedom of movement and the extensive areas for unobstructed comparison that the abdomen offers.

Sometimes I have found definite limitation of expansion at the base of the affected lung which was of distinct help in determining the side of an early lesion; yet I do not place great reliance on it, as I am inclined to think it depends as much on a pleuritic as on intrapulmonary lesion.

Conclusion: The chief point I have tried to develop in this paper is that the general practitioner is the man who should make the early diagnosis of tuberculosis of the lung, and that his most powerful aid to this end is a careful history—seconded by correct balancing of laboratory and x-ray evidence, and lastly helped out by physical examination.

The clinical history is of the utmost and first importance, second, the realization that an early diagnosis can rarely be made with

any exactness, but must be arrived at on reasonable suspicion. Negative laboratory findings must not be accepted as evidence against the diagnosis, and sputum examinations should be repeatedly done. And further, the dictum of the x-ray laboratory should never be accepted as conclusive, but only as corroborative. Of physical signs, localized and constant rales in the upper half of one chest is the only one that seems of any great practical importance in this early stage, and it is more apt to indicate a condition moderately advanced than really early.

If this point of view be correct, the general practitioner is in much better position than any specialist or laboratory man to make the early diagnosis of pulmonary tuberculosis, and the latter should be called upon mainly for the purpose of confirming his opinion and aiding in the decision as to what is best to be done.

* * * * *

So much for the clinical side of our talk. The Executive Committee has asked me to review the work of the Society for the year, and tell you some of our plans for further work; so I will have to trespass on your patience a little longer.

A year ago when your now retiring administration went into office, the most important problems of the County Medical Society seemed to be purely local, and summed up under the heads of: 1, Measures to gain better attendance at meetings; and 2, measures directed toward better organization.

Attendance at meetings is a problem common to most county societies—but we cannot feel that an average of twenty a meeting for the past two years out of an enrolled membership of sixty odd is anything over which to congratulate ourselves. I do not want to take up your time in going over the cause of absenteeism, but we felt that concretely we might meet two objections by offering the best programs possible, and by abolishing from the meetings, as far as might be, tedious business which could be handled outside just as well and perhaps to better effect by officers of the Society.

It seemed wise then to continue the attractive single subject programs which Doctor Costello had sent out to secure during his year as president. This plan gives one subject for an evening's discussion, on which one or several papers from varying angles may be read, but the whole discussion centering around the same general

topic. This idea was followed, and I think the results have been good, because every one who attended the meetings seemed much interested in the papers presented, which were all of high quality and from men well up in their chosen branches of work. Of the spring meeting, particular mention will be made later on because it involves an important phase of the Society's future policy.

The next question—that of doing away with obstructing accumulations of business detail—resolved itself into a matter of better and more efficient organization. And here the problem seemed to center very largely around the president of the society and his functions. He was an entirely inexperienced individual, chosen in September to conduct four meetings, and then retire leaving the conduct of the society to another equally inexperienced. The incoming president to be sure had been vice-president the year before; but had really borne little or no share of the burdens and knew next to nothing about the duties of his office.

There was an Executive Committee which, according to the by-laws, consisted of three members and had only two functions—one to discipline refractory members, the other to arrange programs for meetings. As we have no refractory members, the committee was never called upon to function on the first count; and they quietly and unobtrusively left the second to the president.

So after consultation with Doctor Costello, who had just retired as president, and with Doctor Kice and Doctor Reed, the Secretary and Treasurer, we called and held a meeting of the Executive Committee as then constituted, together with the officers of the society. This meeting was held in November of last year and resulted in the presentation of several amendments to the by-laws, which came to their second reading and adoption at the March meeting. Their general purport you all know.

The Executive Committee, as at present constituted of the officers of the society with three other members, affords real help to the president. There are stated meetings of this committee and it is thus enabled to have a constant check on all the activities of the society, to discuss and conduct routine business, and to formulate and carry out definite policies from year to year. The vice-president, being a member of this committee, can thus become thoroughly familiar with the society activities, its policies, and his future duties.

A further step in the organization was the Nominating Committee, which, elected at the March meeting and reporting at the June meeting, will present a well thought-out ticket for the ensuing year; and by virtue of this fact, any opposition ticket which may be presented must be equally well selected. We are thus insured that whatever ticket or tickets are offered at the annual meeting will be well considered and not hasty last minute selections.

Just a few words in regard to the spring meeting.

In the winter of 1922, Mr. Leonard, President of the Board of Managers of the County Tuberculosis Hospital at Shongum, extended an invitation to the county society to hold its June meeting that year at the Sanatorium, as he was anxious for our members to see the hospital and become familiar with conditions there and with what the hospital was trying to do. President Costello seized the opportunity to secure an exceptionally good speaker for the occasion; an invitation was extended to the public; and there resulted a very successful meeting with an attendance of well over a hundred, the large majority of whom were laymen.

This year the Shongum Board of Managers renewed their invitation; again we had an enthusiastic audience slightly larger than last year's, who listened to an exceptional and instructive address on a public health topic. Mr. Leonard and his board have expressed the wish that this meeting become an annual affair, and preparations are already under way for next spring's meeting.

The importance of these gatherings can scarcely be exaggerated. In the first place we can, I am sure, continue to attract speakers for this type of meeting of the same high calibre we have already had, and it is of exceptional advantage to us to gain in this way first hand information from workers in the field of preventive medicine. This subject is a highly important one for us to be informed upon if we are to hold our proper position in the community as leaders in health matters; and yet it is one with which the ordinary routine of our work does not sufficiently familiarize us.

In the second place, such meetings give us a good opportunity to offer to the public information which it is learning to want, which it ought to have, and is going to acquire in some other way if we do not offer

it. And the fact that we do offer it and direct it, gives us at once a better and more commanding position in the county. We believe that it is merely fulfilling one of the duties we owe the public.

Finally the Freeholders, through their Board of Managers, are running a good, first-class tuberculosis sanatorium at Shongum. It is well located, well equipped, well managed; the patients have the best of nursing and medical care. We may well be proud of such an institution. Despite this, it is very poorly supported by the physicians of the county. No doubt, it is often difficult to persuade patients to go to a local sanitarium—local prejudices are always deterrent—but I believe that one factor in the equation has certainly been our own ignorance of the excellent and reasonable facilities that we have at our door for these cases. Another factor perhaps is too much reliance on the fetish of climate in the cure of tuberculosis. Saranac, Colorado, Ashville, Arizona, and Egypt probably have the best climatic conditons to be found for the care of respiratory disease; but tuberculosis workers today are practically unanimous that climate, though important, is of minor importance, and that education (after diagnosis) is the first and by long odds the great essential, and that this, as a rule may be best obtained in a well conducted sanitarium.

Here close at hand, we have one. These meetings enabled us to get to it, inspect it, know what is going on; and we are neglecting one of our opportunities if we do not make use of it and send our patients there.

The annual meeting for a number of years has been held here at Greystone on the invitation of the Board of Managers of the State Hospital. Doctor Curry, as superintendent of the hospital, has a difficult task which he is handling wonderfully well in the face of much discouragement. He wants all of us to be familiar with this institution, which is one of the largest of its kind anywhere, and which is our institution as well as his. He and his assistants, most of whom are members of the County Society, need and deserve our support.

In regard to plans for one other meeting of the year it has been suggested by a member of the Executive Committee that we should do something to encourage our own members in original work. To this end, the committee has decided to try one meeting this year at which a symposium shall be held on some given topic, with several short

papers on various phases of the subject, limited to fifteen or twenty minutes each, and the work entirely by members of the County Society. We believe that such a meeting is worth trying out and should encourage us all to express our own opinions on subjects we are certainly qualified to discuss, at any rate amongst ourselves.

It would hardly be gracious of me to close without an expression of my appreciation for what the Executive Committee has done during the year. Each meeting called has been fully attended and the most active interest manifested; every one has done willingly and carefully the work asked of him. Whatever of accomplishment there has been, has been due to their backing and initiative, and the year's experience has convinced me that it is possible for us as a society to carry on to a much higher standard of usefulness both to ourselves and to the community we serve in the years that follow.

PRESIDENTIAL ADDRESS.

Delivered at the Annual Meeting of the Essex County Medical Society, October 2, 1923.

By Augustus J. Mitchell, M.D.,
Newark, N. J.

The scientific work of this society is well taken care of by the Academy of Medicine. I, therefore, selected a topic that is at the present moment of great importance relating to the health and well being of this great country at large. The working of Prohibition from the viewpoint of the physician. And I have compiled figures and facts for your consideration.

The City Hospital and Police Department of Newark report as follow: The alcoholics admitted to the City Hospital jumped from 369 in 1918 to 1,658 in 1922, and for the first 9 months of 1923 the total admissions have been 1,958. The total number of arrests for all causes jumped from 9,771 in 1914 to 15,404 in 1922. Crimes of immorality show a substantial increase during the past 3 years. Cases of narcotics have increased 50 per cent. in this period, and cases of non-support and desertion have increased 25 per cent. within 3 years, and show an increase of nearly 35 per cent. since 1914. Nor are these exceptional figures. Dr. S. Dana Hubbard of the New York Board of Health reports that the number of admissions of cases of alcoholism in the city hospitals jumped from 1,758 in 1918 to 5,624 in 1922. The arrests

for drunkenness as reported by the Police Commissioner in New York show a 47 per cent. increase for 1922 over 1918.

Dr. John Nevin, Medical Director of the City Hospital, Jersey City, reported last January that the admissions for alcoholism and drug addiction are on the increase. During the 3 years from July 1, 1916, to June 30, 1919, there were 1,570 alcoholics and 72 drug habitues admitted. During the next 2 and a half years, running from July 1, 1919, to December 31, 1922, the number of alcoholics was 1,664 and drug addicts 219.

Dr. John A. Houston, Superintendent of the State Hospital for the Insane at Northampton, Mass., reports that commitments due to the use of alcoholic beverages have practically doubled over the previous year, and actually show an increase over 1918. Practically identical figures are given by Dr. John B. MacDonald, Superintendent of the Danvers State Hospital for the Insane in Massachusetts. Dr. Houston in his report which was dated August 17, 1922 said: "Were this true for my hospital alone I might ascribe the condition to local laxity of Federal enforcement, but it is interesting to note that the statistics for the entire United States, compiled by Dr. Horatio M. Pollock, statistician of the New York State Hospital Commission, are practically the same as at the hospital here, that is, they show that in the last recorded year, the increase of those who went insane through the use of alcoholic drinks from the Pacific to the Atlantic coasts, was practically double that of the previous year. Thus it would appear from wholly reliable records that the illicit use of alcoholic beverages throughout the country has gone far beyond the power of enforcement officers to cope with it."

Police records in some 19 cities representing 14 different States—North, East, West and South—show an increase of only 7 per cent. in 1922 over 1921 in arrests for all causes, but the increase in the cases of drunkenness was 35 per cent., and the arrests of intoxicated auto drivers increased 22 per cent. Aside from these figures we must include hundreds of cases without official record, but seen in private practice.

I must not burden you with any more statistics. The point is that public drunkenness is in the increase in all the centers of population, and that cases of acute alcoholism are increasing steadily. There

is no doubt that prohibition has enormous increased the number of deaths from wo alcohol and other poisonous alcohol liquors. The Philadelphia coroner reported recently the death of 40 persons from drinking such liquor in the short period of six weeks. Similar reports might be cited from many other sources.

Undoubtedly, the attitude of the medical profession has undergone a great change during the 4 years of actual operation of the prohibition law. No one realizes the evils of intemperance better than the physician does. If we were to reveal the professional secrets of our consultation chambers they would tell a startling story of human frailty which would show that gluttony and intemperance are among the main causes of disease.

I think it is safe to say that doctors have taught more real temperance than the professional moralists have. Many of us were hopeful that National Prohibition would prove the solution of the drink problem, and we listened with willing ears to the prediction that under it the young generation would grow up without having acquired the taste for intoxicants. Unfortunately, we know from our own professional experience, as well as from observation, that intemperance, particularly among the young, is greater than it was ten years ago. Drinking in colleges has become a serious problem for the university administrators. Club dances and social gatherings of all kinds are constantly bringing scandals to the surface. It is, in fact, the smart thing among young people to carry liquor with them wherever they go, and to drink it on all occasions. Of course, they carry the form of liquor which has the highest amount of alcohol in proportion to its bulk. Most of it is crude raw stuff which is thoroughly injurious apart from its intoxicating qualities.

There is one outstanding feature of the enforcement of National Prohibition which has done more to prejudice the doctors than anything else, and that is the restrictions which have been put upon their rights to prescribe what they think their patients require. There is absolutely nothing in the Eighteenth Amendment which justifies or excuses these restrictions. The prohibition in the Eighteenth Amendment is limited to the manufacture, sale or transportation of intoxicating liquors for beverage purposes. In order to make the law operative the amendment gave Congress the right to pass "appropriate legislation" for the enforce-

ment of prohibition. It is commonly reported that this regulatory measure which known as the Volstead Act, was really drawn by the attorneys of the Anti-Saloon League, whose attitude toward the physician was one of damnable suspicion. As Dr. Warren Coleman of New York has said: "The medical restrictions of the Volstead Act constitute an indictment against the integrity of the entire medical profession." Doctors are, however, so engrossed in the practice of their profession than any concerted movement against an abuse of this sort comes slowly, and organized action becomes possible only when a deep feeling of resentment has been aroused by an act of injustice which affects their professional status and their ability to exercise their judgment for their patients. During the past year, however, the sense of the outrage which had been perpetrated on the medical profession culminated in the passage of resolutions by many medical societies in different parts of the country. The climax was reached in the test case brought by over 100 of the leading physicians in New York, who organized themselves into an association for the Protection of Constitutional Rights, and selected Dr. Samuel W. Lambert of the College of Physicians and Surgeons of Columbia University to bring a test case in court. As you know, Judge John G. Knox in the U. S. District Court decided last May in favor of the physicians, declaring in effect that it was for the attending physician and not for Congress to decide how much alcohol was needed as a medicine by a given patient in a given case. He declared that it was not the function of Congress to invade the domain of medical authority. The case was bitterly fought, and the prohibition leaders and officials have taken the decision with very bad grace, and are apparently doing everything they can to limit its operation to the small Federal District over which the court had jurisdiction. However, Judge Bourquin of the U. S. District Court of Montana has since given a decision which is parallel to that of Judge Knox, in which he declares that the limitation in the Volstead Act "is an extravagant and unreasonable attempt to subordinate the judgment of the attending physician to that of Congress in respect to matters with which the former alone is competent to deal, and infringes upon the attitude of the patient to receive the benefit of the judgment of the physician of his choice."

There is another aspect of the matter

which is of public interest, and which cannot be made a matter of judicial interpretation at this time. The replies to the questionnaires which have been sent out to physicians of this country make it clear that a majority of them believe in the therapeutic value of whiskey in the treatment of certain diseases. The prohibition authorities themselves have been impelled to relax the rigidity of their rules during the presence of epidemics such as influenza or pneumonia. It is one thing, however, for the physician to prescribe it, and quite another thing for the patient to get it. Much of the whiskey which is sold in drug stores has been adulterated or emasculated, or is synthetic stuff which is of no value. Moreover, the price is extortionate and beyond the reach of poor people. Congress must face this question and the best solution in my mind is for the Federal Government itself to establish its own depots, furnishing the whiskey in sealed packages, guaranteeing its purity and good quality, and selling it for medicinal use only, at a reasonable figure. In this way the government can best control the disposition of spirits, etc., for proper medical use; the public will be inconvenienced and protected, and the revenue which could readily be obtained would cover many times the cost of the operation of such a plan.

To sum it all up, the Eighteenth Amendment is perhaps the most revolutionary social experiment ever undertaken by a great nation. The success of this experiment depends, of course, upon its winning popular favor. You can not change the traditional habits of a nation of over 110,000,000 people by force. Let us concede for the sake of argument, that the National Enforcement Act, which is popularly known as the Volstead Act, was an honest attempt to make the Eighteenth Amendment workable; but it is not the last word on the subject. Is it not indeed unreasonable to expect that such a measure as this could be perfected at the first attempt? The Volstead Act is not a sacred document. The next Congress can modify or amend it by a majority vote. Four years of its operation have exposed its weakness. There would be no trouble about the matter if it were not for the intolerant attitude of those who are professionally engaged in the exploitation of prohibition. They are, I believe, doing the cause of temperance a great injury, and it is evident that if the leaders of the prohibition movement wish to be trusted that they must change their attitude on this question.

There are hundreds of thousands of sober-minded people who have a real passion for temperance, and who are bitterly disappointed over the failure of prohibition. The palpable remedy is to re-value the Volstead Act in the light of its failure, and bring the pressure of public opinion to bear upon our Congressional Representatives so that they will appreciate the demand for its modification.

As physicians, who are concerned in the life, health and welfare of the people, and as citizens, we cannot close our eyes to the present intolerable conditions. Drastic measures of enforcement will not restore temperance to the American people. Their confidence and support can only be won by fair and reasonable treatment. As a first step the Volstead Act must be made to conform to the spirit and intent of the Eighteenth Amendment.

In conclusion, I want to thank you for the honor of choosing me your presiding officer.

SPECIAL INDICATIONS FOR THE USE OF DIGITALIS AND QUIN- IDINE*

By Harold E. S. Pardee, M.D.,

Assisting Attending Physician, New York Hospital;
Associate in Medicine, Cornell
University Medical School.

The treatment of heart disease has become much more effective of recent years. We have learned so much about the physiology of normal and abnormal hearts that treatment now has at its foundation a large mass of fact which enables us to attempt things that would not before have seemed possible. Besides this our knowledge of the absorption, action and elimination of the cardiac drugs has been greatly extended.

It was not so very long ago that physicians only knew that digitalis was the drug of preference when the heart was beleived "to need stimulation." If the desired improvement did not appear on using it, we tried strophanthus or convallaria, or apocyanum or squill, or probably two or three of these would be given at once, hoping for a synergistic action. Our knowledge of these drugs has progressed and our opinions crystallized, so that we now know that strophanthus has a very uncertain and variable action because it is so slowly absorbed and so rapidly exerted. We know also that con-

vallaria and squill and apocyanum are weak and ineffective in comparison to digitalis.

One of the most important things we have learned in regard to digitalis is that the dosage must be sufficient. More harm is done through giving too small amounts of digitalis and expecting results from them than can possibly be imagined. True, that such doses as 10 minims of the tincture, three times a day will sometimes produce effects if persisted in for three or four weeks, but it is not until the end of this period that the effects become apparent, if then, and in serious cases the patient might die before the digitalis effect came on. We know that the drug does not show its real value until it reaches a certain concentration within the body, which I will call the *therapeutic concentration*. The sooner this therapeutic concentration is reached the sooner the heart will be strongly affected and so it is quite illogical to start with small doses of digitalis which will only very slowly accumulate to an effective concentration in the body. The therapeutic concentration is produced by an amount that on the average is very close to 2 minims of tincture of an average potent leaf, per pound of the patient's weight excluding weight due to oedema. This would be then 240 minims for a patient of 120 pounds, 300 minims for a patient of 150 pounds. The matter of the correct dosage for the individual patient is not as simple as these figures would lead one to expect; these figures are an average, and different patients vary greatly in their susceptibility, some needing 25 per cent or 30 per cent. less than this average, and some 25 per cent. or 30 per cent. more, so that the therapeutic concentration for a patient of 120 pounds might be reached after 180 minims if he were unusually susceptible or not until 300 minims had been given if he were unusually resistant. If we attempt to reach the therapeutic concentration too abruptly we shall overdose occasional patients who have more than the average susceptibility. This is especially true if we are using a digitalis of unknown potency.

We shall be safe from such danger even when dealing with a digitalis of unknown potency, with a dose of 1 minim of tincture per pound of the patient's weight in starting a course of digitalis treatment. 120 minims of tincture for a patient of 120 pounds or 150 minims for a patient of 150 pounds divided into 3 doses 8 hours apart will never produce more than slight signs of toxic action, and usually not any at all

*Read before the Hoboken Medical Society,
May 15, 1923.

provided that the patient has not had any digitalis or any of the allied drugs within a period of ten days. This dose will always produce a definite and demonstrable effect on the heart action. If auricular fibrillation should be present, we shall notice a slowing of the ventricular rate, and in any case, the electrocardiographic record will show the change in the T wave which results from the action of digitalis upon the ventricular muscle.

This dose of 1 minim per pound does not ordinarily produce the full therapeutic effect, so we should continue to give digitalis 20 minims 2 or 3 times a day until this is manifested by an improvement in the patient's symptoms, or until such signs of poisoning as coupled beats or nausea make their appearance. We should not stop the drug until either therapeutic or toxic effects are observed, for only then, no matter how much has been given, can we know for a certainty that the therapeutic concentration has been reached. Having reached the therapeutic concentration we desire to maintain it and to do this must continue to give digitalis as fast as the drug is exerted. We might call this a *maintenance dosage*. A common error in digitalis administration is to stop the drug after reaching a full therapeutic effect, for by this stopping we lose the therapeutic concentration. It should not be stopped at all when the therapeutic effect has been obtained but only reduced in dosage. If signs of poisoning have appeared, it should be stopped until these have gone and for 48 hours more and should then be resumed with the maintenance dosage.

The excretion of the drug is variable with different patients but usually lies between 2 and 3 grains of the leaf per day, so that 20 to 30 minims of tincture is the dose to give to maintain the therapeutic effect. It is best given as a single dose at night. There is no reason for dividing it up throughout the day, and the more frequent doses are an unnecessary source of annoyance to the patient. When ordering the tincture do not consider drops equal to minims. This is probably the commonest error made by physicians today in ordering digitalis, and leads to under dosage and failure to obtain effects. Ten minims of the tincture of digitalis will take from 18 to 30 drops, depending upon the shape of the dropper, the position in which it is held and the speed of dropping, so that, 30 minims might be 54 or 90 drops in different cases. Either the patient should have a

graduated measuring glass or pipette or a mixture of the tincture in water should be prescribed so that there are ten minims or twenty minims to the teaspoonful, and the teaspoonful should be used for measuring the daily dose.

In considering what type of case demands digitalis treatment, it has become plain that it is not the mere presence of heart disease which makes digitalis necessary. There are many patients who have rather extensive heart disease and yet do not need this medication. No matter how severe the pathology may be, we feel that digitalis is only indicated by the presence of symptoms of cardiac insufficiency. There is no question, of course, about the advisability of giving digitalis to the severely sick bed patient whether the heart is regular or irregular, but it is not so generally realized that ambulatory patients who complain of shortness of breath on ordinary exertions are helped by the drug. A course of digitalis lasting for from three to six weeks will help most patients with these symptoms even though the heart is regular and not especially rapid.

If the patient has the continuously irregular heart due to auricular fibrillation, and if the heart rate tends to be 90 per minute or more when the patient is at rest or goes to unusually high rates after exercise, then this patient should receive digitalis to slow the heart rate whether he has dyspnea or palpitation on exertion or not. The continual rapid beating tires the muscle and leads to a limitation of the ability to exercise. This limitation may entirely disappear when the rate is slowed to within normal limits. These patients then must continue to take digitalis as long as they have auricular fibrillation, in a daily dose sufficient to keep the heart at the proper rate of beating i. e., between 70 and 80 per minute.

The treatment of these patients with the irregular heart of auricular fibrillation has lately had a new phase revealed by the discovery of the action of quinidine. Quinidine is not a heart stimulant or tonic drug, it is, in fact, a depressant to the cardiac muscle, but it has the peculiar ability of being able to abolish auricular fibrillation, so that the previously irregular heart, beats again by the normal mechanism. The return to normal rhythm takes place in somewhat more than half of all patients who have auricular fibrillation but some relapse again to the irregular action in a few days or hours, so that for practical purposes the treatment is effectual in about 40 per cent.

of the patients. If a patient remains with normal rhythm for a week or ten days before relapsing to auricular fibrillation it is usually possible by a further course of quinidine to return the normal rhythm in from 24 to 36 hours, and it may persist this time for seven to ten days or more, or less. Some patients retain the normal rhythm for weeks after quinidine treatment and some for months or years.

The present state of our knowledge is so incomplete that we cannot say in advance whether a given patient will return to normal rhythm or not, or if he does, how long this will remain. On the average a favorable reaction to quinidine is not as frequent in patients with advanced valvular disease or patients with large hearts, as in those without valvular disease and without cardiac enlargements, but the individual patient often fails to follow the average behavior of the group. Many with much enlarged hearts or advanced valvular disease or both can be returned to normal rhythm by quinidine, and some will retain this for a considerable time. I feel that at present, every patient who has auricular fibrillation should have a trial with quinidine to see whether his heart cannot be returned to normal rhythm for the patient is nearly always more comfortable with the heart beating regularly.

There are certain dangers connected with the use of quinidine which should be clearly in the physician's mind in order to, as far as possible, avoid them. One danger lies in the fact that it is a depressant to the cardiac contractility, which results in a certain degree of weakening of the cardiac force in any patient to whom it is given. This effect only rarely causes an appreciable degree of cardiac failure during the administration of the drug, but it represents an influence which tends to be harmful rather than beneficial. In addition to this, quinidine tends to produce in certain patients while under treatment, a very rapid ventricular rate. If this rapid rate is long persisted in, it will lead to a greater or lesser degree of cardiac failure, from fatigue of the muscle. There are, thus, these two factors, the toxic action on the muscle, and the rapid rate, which tend to cause cardiac failure during the quinidine treatment. We must carefully watch the patients while under treatment, for signs of the onset of failure, or for an increase in the signs already present. If quinidine is seen to be doing harm in this way, it should be promptly stopped, for, I have seen very serious failure result from

continuing the drug after it had become evident that it was causing decompensation.

This tendency to cause decompensation should not amount to a serious danger for it is easy to avoid if care is used. The one serious danger from quinidine is the possibility of sudden death. This occurs very infrequently, in less than 1 per cent. of patients, but when it has once happened there is no redress. It is believed to be due to cerebral embolism, the clot coming from the interior of the left auricle. During fibrillation of the auricles they remain in the diastolic position so that clots would tend to form because of stasis in the dilated auricular appendix. These clots are sometimes pushed out into the blood stream when the auricle begins to contract normally.

For this reason we should never attempt the quinidine treatment at any time less than four weeks' after a period of severe decompensation. During this four weeks any clots that may have formed in the auricles will have become adherent, so that they will not be so readily thrown into the circulation. Furthermore, the four weeks' treatment with digitalis will improve the condition of the circulation, and thereby the nutrition of the muscle of the auricles, and by this will probably tend to favor the return to normal rhythm. I have, on several occasions, found a second course of quinidine to be successful when it was given two or three weeks after an unsuccessful one and have often found the second course to result in a longer period of normal rhythm than the first. I attributed both these results to the improved condition of the auricular muscle which resulted from the additional period of improved circulation.

Ventricular fibrillation may on rare occasions be a cause of the sudden death during quinidine treatment. Ventricular tachycardia has been observed in patients under quinidine and in dog experiments ventricular fibrillation itself has been noted. We do not know what predisposes to this but it seems likely that the better the condition of the muscle the less the chances would be. This is an additional argument in favor of getting the heart in as good condition as possible before trying the quinidine.

The danger from the use of quinidine must be contrasted with the dangers of continuing to have auricular fibrillation. The danger is slight if the patient is faithful in following out this digitalis treatment so that his heart rate can be controlled by this. Occasionally sudden death occurs in these

patients, due to cerebral embolism, and occasionally they have emboli in the arteries of the extremities or the abdomen. Many of them have a more or less unpleasant sensation in the chest due to the irregular heart action, and all of them must take digitalis throughout their life.

Patients who are not faithful in carrying out digitalis treatment and who have a too rapid heart most of the time are in much greater danger of having emboli, and even without them the heart tends to a condition of chronic fatigue, which results in chronic myocardial changes. These patients tend more or less rapidly downward, and for them the quinidine is especially indicated.

During the initial treatment with quinidine, patients should be in bed and under close observation, but a patient who has once been returned to normal rhythm by quinidine and relapses to fibrillation again, need not be so closely watched nor so closely confined during a second treatment. The first treatment should be preceded by a test dose of 6 grains of quinidine sulphate to see if the patient has marked susceptibility as shown by buzzing in the ears, headache, nausea, or general weakness. If not, then 6 grains every four hours should be given on the next day, giving 4 doses for the first two days and if normal rhythm has not resulted, giving 5 or 6 doses daily thereafter. The patient should be seen every day and watch kept for signs of intoxication. It is hardly worth while to continue the treatment for more than six days in all, for those who return to normal rhythm after as much quinidine as this are not likely to continue with it long before reverting to fibrillation.

Sometimes the patient's reaction to the drug will demand its withdrawal. Palpitation, which is very marked, headache, nausea, vomiting or diarrhea, may appear and indicate a harmful effect of the quinidine, or, as has been already mentioned signs of decompensation may appear to be increasing.

Whenever the patient returns to normal rhythm, and usually they are able to realize this themselves, the quinidine should be discontinued for that day. A dose of 6 grains should then be given every morning and night for several days following, as a prophylactic against the return of the fibrillation. The patient may now be allowed out of bed as soon as his state of compensation and general health warrant it.

A theoretical objection has been raised to

giving quinidine while the patient is under the influence of digitalis. Quinidine paralyzes the vague endings, an action which helps to abolish the fibrillation, while digitalis stimulates the vague therefore tending to oppose the quinidine. The matter is of more theoretical than practical importance, for those who disregard it are able to report just as good results from quinidine as those who do not.

A patient whose return to normal rhythm is only for a brief time does not receive much benefit, but when normal rhythm persists for from seven to ten days or more the patients usually feel much better. They have a consciousness that the heart is acting normally; they are released from the need to take digitalis continuously to keep down the ventricular rate; and they have what little mechanical advantage accrues from the regular beating and from the presence of the auricular systole.

I wish to emphasize particularly that quinidine is an improper drug to use in the presence of a severely failing heart. It tends to increase the cardiac failure and if normal rhythm is not quickly attained may do irreparable harm. Moreover the danger of embolism is greater at this time. First treat the cardiac failure with digitalis and then if auricular fibrillation persists treat this with quinidine.

Other forms of cardiac arrhythmia may be benefited by quinidine. Paroxysms of rapid heart action occur because of auricular fibrillation or auricular flutter or the rapid regular activity of some abnormal site of impulse formation called paroxysmal tachycardia. The paroxysms may be of short or long duration, they may occur frequently or infrequently, but always their occurrence is a distressing event to the patient. Quinidine is often capable of stopping these paroxysms whatever their mechanism. It should be given in a 6 grain dose immediately after the onset, and repeated at 2-hour intervals for two or three doses if the attack persists. If one or more attacks occur daily, quinidine may greatly diminish their frequency or even entirely stop their occurrence. For this purpose 6 grains before breakfast, repeated 6 hours later, has been found very successful, though one dose each morning may suffice or 3 grains before each meal. I have seen no harmful results from continuing this dosage for many months.

The irregular heart action, due to premature beats, is not ordinarily a reason for treatment, as it does not lead to cardiac in-

sufficiency or any other harm to the patient. Sometimes it is felt by the patient as a discomfort in the chest or even as a pain over the heart and it then warrants treatment. Quinidine has been found of value for this purpose also and should be given as described for the prevention of paroxysmal attacks.

THE PLACE OF THE SANATORIUM IN THE TUBERCULOSIS CAM- PAIGN.

By Martin I. Marshak, M.D.,

Bayonne, N. J.

A complete campaign against tuberculosis should be waged by two distinct methods, the direct and indirect. The indirect, which includes, the publicity and educational campaigns, the better housing and working conditions campaigns, the child welfare and other kindred movements, teach the public something of tuberculosis, raise the general resistance to all disease and diminish the public hazard to disease and injuries. The direct takes in any means of actual combat against the tubercle bacillus per-se and the problem of the tuberculous individual. As the subject allotted to us is, the place of the sanatorium in the tuberculosis campaigns, we will try to make a survey of this mode of attack.

A proper direct attack must of necessity be made up of the following factors: (1) The dispensary with its nursing and general follow-up system; (2) open air schools, day and night camps; (3) The sanatorium and tuberculosis hospital; (4) the post-sanatorium follow-up; (5) some industrial plan for the below par workers; (6) necessary anti-spitting laws. The Sanatorium and Tuberculosis Hospital should be the center toward and from which the various other factors lead.

The dispensary with its nursing and general follow-up system is the machinery by which cases are discovered. Although a number of these cases are handled from the standpoint of home treatment or possibly along methods outlined in factor number two, its important outlet is after all the Sanatorium. Open air schools have demonstrated their value during the past fifteen years. In fact a school system without such equipment is considered in many States as being derelict in its duties toward a certain class of citizens who could not obtain an education in any other way. Day and night camps are after all but an attempt to conduct a sanatorium regime close to home.

They have some value, but many times produce a feeling of security which prevents some tuberculous individuals from obtaining the proper atmosphere for a cure.

The sanatorium and tuberculosis hospital. These are grouped because, to be of real value in the tuberculosis campaign facilities for taking care of all types of tuberculous patient must be had.

What are the functions of the sanatorium:

(1) To serve as a place for cureable cases to take the cure.

(2) To treat acute breakdowns in old cases.

(3) To serve as a haven of last resort for those who have exhausted other means and must have a comfortable and safe place to spend their last suffering days.

(4) To keep positive sputum cases away from contact with society until they learn how to live with safety to others as well as to themselves.

(5) To teach the public, both the tuberculous and others how to live, hygienically, naturally and unselfishly.

(6) To be the center of tuberculosis study and instruction for the medical profession as well as for the social workers of the community.

(7) To start the below par workers on his way to becoming an asset instead of a liability to society.

Curable cases are most rapidly cured at the smallest cost in the environment of a sanatorium with its regulated life and under the constant supervision of competent physicians. These are usually the cases that lose their symptoms readily and because they feel so well must be closely watched so that they do nothing which may produce a breakdown. Home treatment in these cases because they feel so well cannot be readily controlled. Instruction in tuberculosis and its dangers to themselves and the community are thoroughly impressed and by constant repetition the daily routine becomes in part a habit which is persisted in throughout life and really has a great deal to do with the continuation of their good health and well being.

As many patients cannot be forced to remain in the institution, and many will not stay long enough for a permanent repair. Some leave as improved, others as quiescent. Naturally in again entering the struggle for existence, some break down. A great many of these breakdowns can be made temporary and of short duration if there are facilities for giving immediate care and treat-

ment. This function if it is properly handled will make a great many individuals economic producers for a good portion of their life, and will prolong that life and prevent many from falling by the wayside.

There comes a time in life when care and comfort for the last remaining days are necessary. The hospital end of the sanatorium should be properly used here. As tuberculosis is without doubt a socio-economic disease, the victims of the disease deserves from the public every facility for making their last illness as easy as possible. If these individuals are left at home, they act as a prolific source of infection to others. Because of the severe drain on the purse of the average family they reach the edge of the abyss of economic dependence. Relieving them of this load keeps the family independent, and allows the children to grow up in a better home atmosphere, and one not constantly charged with millions of tubercle bacilli.

A number of states have laws requiring all sputum positive cases to be isolated. Whether this a fair law or class legislation is not for us to discuss here. Individuals with positive sputum should be isolated, at least to such a time, when by reason of practice and instruction they shall instinctively live the correct hygienic life. They then become of minimal danger to others.

The teaching side of the sanatorium is not sufficiently stressed. Teach, teach, teach should be the slogan. The sanatorium graduates should be so well taught that they themselves instinctively teach their relatives and neighbors. What is tuberculosis, how is it usually contracted, how can it be prevented? How can it be recognized early, in the cureable stages. What is the hygienic, the natural, the unselfish life. The more the public is taught to think tuberculosially, the quicker will be the ultimate results.

A sanatorium and hospital should be so equipped that physicians the state over shall look upon it as the center of tuberculosis study and research. Courses should be given and practitioners should be induced to attend. The institution should be made a part of the state medical training course and a part of each student's time should be assigned to practical tuberculosis training in the sanatorium. Social workers who must in the course of their work come in contact with tuberculosis should be induced to learn something of what they try to combat by courses in the sanatorium. The bond between the social worker and the sanatorium should be a great deal closer than it is, in

order to obtain results. A course at the sanatorium would tighten that bond.

Our patients have been brought to the state where it becomes a question as to, where shall we go from here, what shall we do? Should the sanatorium wash its hands and say our work is done, another agency must take this up? No. The beginning of economic independence should be made at the sanatorium. Shall the patient become a healthy loafer? Many are becoming such! No. They must be inspired with the thought that the trail back to economic independence is the only trail worth traveling. The sanatorium takes the first step with its graduated exercise, its occupational therapy department, and the vocational training outlets.

After the sanatorium, economic independence may have or may not have been attained. For statistical studies, for retaining a control on the sanatorium alumnus, for keeping up his moral and for continuing instructions; a follow-up system is essential, but must be diplomatically and sympathetically handled to obtain the best results.

Ultimate results depend on how hard the struggle for existence shall be. The world over, as a result of the aftermath of the war, the question of what to do with the below par worker has become a vital one. Unless some work is done along this line, our direct attack on the tuberculosis problem shall be incomplete. As the life struggle is severe so do the number of re-admissions to the institution increase. As the tuberculous below par workers are so, most frequently through public faults, the public should give them an opportunity of becoming economically independent and not make them go back into life to compete with healthy men.

So we find that the sanatorium is really the center to which some agencies lead, and from which others radiate in the tuberculosis campaign.

CANCER PATHOLOGY.*

By John W. Gray, M.D.,
Newark, N. J.

Cancer is a general term for all malignant tumors, including both carcinoma and sarcoma. The pathology of cancer is important regarding etiology, diagnosis, prognosis and treatment.

The cause of cancer is not known. All

*Read at the St. Barnabas' Hospital Staff Meeting on December 27, 1923.

that we can say is that there must be some biological change in the cell or cells which permits overgrowth. A large amount of experimental work has been done on animal cancer since 1903 when Jensen showed that malignant tumors could be transplanted in mice and rats. Loeb assumes that a transmitted constitution plus the co-operation of multiple factors determines the intensity of tumor development in certain individuals and that the greater the intensity the earlier the growth appears. Wood shows that the incidence of mice cancer can be increased by inbreeding. Cohnheim's theory of misplaced embryonal cells explains the formation of certain mixed tumors, but does not explain why these tumors remain dormant until adult life and then suddenly become active and malignant. Much has been said regarding the infectious origin of cancer but all evidence to date is against infection as a cause. No instance of cancer transfer is recorded except by the use of unbroken cancer cells and even then the percentage of takes is small. Recent experiments by the Crocker Special Research Fund show that by painting mice with tar, skin cancer can be produced in 100 per cent., and that sarcoma develops in rats infested by parasites causing liver cysts. Even though continued irritation is thus proven to be one of the multiple factors in the causation of cancer, it is not the real cause and does not help much in the prevention and treatment of the disease.

Carcinoma and sarcoma (except lymphosarcoma) are in the beginning localized in a small area. Only one hope of curing the patient is at present available and that is by making an early diagnosis and eliminating the localized growth. The chance of doing this in cases where the growth is not visible or palpable is small because by the time symptoms and signs of an internal growth are sufficiently developed for a diagnosis the condition is no longer localized. Unfortunately there are no specific laboratory tests for cancer. No substances are developed in the system by the cancer cells that may not develop from the normal parent cells from which the growth is derived. The Abderhalden test and others, much heralded at one time, as specific, are valueless. The x-ray is the most valuable aid in diagnosis of internal cancer, particularly of the gastro-intestinal tract. The gastric analysis and stool examination are of some assistance. In certain cases the pathologist can render service by making a "quick section"

of the growth. There may be some danger associated with the incision of a tumor, but the risk of waiting is greater than the risk of incising. If the surgeon is ready to carry on the operation as soon as the diagnosis from the pathologist is received, the danger of disseminating the growth may be avoided. In case of small rigid ulcerating tumors, a Wassermann test should be done rather than waiting for the results of treatment. Frequently, carcinoma of the mouth shows temporary improvement with anti-syphilitic treatment, thus adding confusion. If the Wassermann is negative after a provocative test, the condition should be considered neoplastic and treated accordingly.

The examination of a growth after removal may be of considerable prognostic importance. For example: If an ovarian tumor is papilloma rather than carcinoma and unruptured, it will not recur. In case of a suspicious growth around an excised gastric ulcer, the report of inflammatory tissue is most gratifying to the surgeon and important for the patient. Many times an innocent appearing tumor may prove to be actively malignant and visa versa. Foreign body giant-cell sarcoma of the bone and tendon sheath are essentially benign tumors and can be cured by excision and curettage. Nevertheless many limbs have been sacrificed because of inaccurate diagnosis or failure to understand the relative malignancy of these bone tumors. Microscopical examination of axillary contents following breast amputation shows whether the lymph nodes are involved or uninvolved, which practically means life or death to the patient. In rare cases constitutional immunity may account for the slow progress of cancer—for instance, scirrhus carcinoma of the breast in elderly people. Furthermore, some embolic particles of malignant tumors in the circulation may never get a foothold and form metastases. This may account for rare cases of well advanced carcinoma being cured by surgery. Tumors composed of small cells metastasize more readily than those composed of large cells because they enter the lymph or blood vessels more easily. Carcinoma usually metastasizes through the lymphatics and sarcoma through the blood vessels.

The rationale of radium and x-ray therapy for cancer is that the disease cells are more easily destroyed than healthy cells. Unless all cancer cells are destroyed, recurrence will result for metastases may occur from a regressing or quiescent tumor. The per-

meation of cancer cells may be checked by fibrosis of the lymphatics. On the other hand, a natural barrier may be destroyed by the destruction of lymphoid tissue. Regarding recent attempts to immunize the individual by irradiated cells from his own tumor, Wood says, "It is very improbable that a person can be immunized against his own tissues. The 'immunity' which has been demonstrated in animals is a form of resistance to transplantation of a tumor to a healthy animal. No immunity to growth of a primary tumor has ever been demonstrated."

CANCER OF THYROID.*

By John F. Hagerty, M.D.,
Newark, N. J.

Fortunately for us, Cancer of the Thyroid is of infrequent occurrence; various authors stating that it occurs in 1 to 3 per cent. of cases. In Crile's Clinic it occurred in 1.8 per cent. In Mayo's Clinic in 14,000 cases studied the percentage was 1.19 per cent., and in other clinics about on the average of 2 per cent. These figures, too, refer to cancer in goiter cases—not normal thyroid cases.

Hertzler, of Kansas City, in his recent book devotes one page to the subject. He says the disease is diagnosticated more often than it exists. Says surgeon who cures carcinoma of thyroid, places a heavy burden on his pathologist.

Surgery, Gynecology and Obstetrics, whose monthly review of surgical subjects is very thorough, had but one or two references to cancer of thyroid during the past year. Yet in spite of the paucity of literature dealing with cancer of the thyroid—the disease does exist and presents some unusual features worthy of consideration. To understand the subject we have to think of the histology of the thyroid and the rather frequent occurrence of a structure known as foetal adenomata.

These so-called Wolfer's rests, formed from embryological tissues and thus of congenital origin are circumscribed masses of thyroid tissue, non-lobulated, and which in the early stages are not capsulated and contain no colloid or iodine. They may remain in this condition throughout life or start growing at any time. In their growth the cells become differentiated and may develop follicles with both. These masses are more

yellowish in color than normal tissue and may be detected macroscopically. In their growth and development the more they resemble developed thyroid tissue the less likely they are to become malignant. Malignant adenoma arises from foetal adenoma, but, dependent on the time at which examination is made, varying opinions may be obtained as to the degree of malignancy. Many patients have such growths for years without evidence of malignancy—that is without metastases and Crile refers to these masses as pre-cancerous tissue.

Histologically, malignant adenoma differs from ordinary cancer. There is not as in cancer irregular epithelial masses surrounded by connective tissue, but the new formed tumor with its vesicles resembles more a normal organ in course of development. These tumors are soft, yellowish, while cancers of thyroid are hard, nodular tumors freely adherent to surrounding tissues. The cut surfaces of the latter is grayish-white and typical cancer juice can be expressed. Langhans and his pupils of Berne were the first to show that these embryological rests may remain included in the thyroid and at times give rise to malignant growth. These growths metastasize through the blood stream and hence invade distant parts, more especially bones and lungs; and of the bones, the skull, sternum and pelvis are most frequently involved. There may be no glandular involvement and the thyroid itself often shows no sign of disease.

Metastases in bones are more common from cancer of the thyroid than from any other organ, the prostate being next. Metastases in bones are not as a rule multiple, though they may recur at later dates.

A marked peculiarity of metastases in malignant adenoma is their ability to revert to normal thyroid tissue. Crotti states that this does not occur in carcinoma metastases from any other organ. At times cells are found in these tumors which secrete colloid. That such metastases are capable of normal physiological action is proven by a case of von Eiselburg. Complete thyroidectomy was performed for malignant tumor. The patient survived and remained well. Later a metastatic growth was removed, myxoedema followed.

Ninety-five per cent of all malignant growths of the thyroid are carcinomatous and fully 90 per cent. of these develop from foetal adenoma. There is a peculiar tendency to penetrate the walls of the veins, even in early stages of growth and, where clinically the case does not seem advanced,

*Read at the St. Barnabas' Hospital Staff Meeting, Newark, December 27, 1923.

metastases may have started through the venous circulation.

Tumors of the bone due to metastatic thyroid cancer can not be recognized clinically. They may be thought to be sarcomata. Cohnheim and others used to regard them as benign; but others agree that a tumor that can metastasize can not be benign. There have been cases, however, where the metastatic growth was found to be simple goitre, which after removal was not followed by recurrence. This feature of the subject is so interesting, much time might be spent on it. I shall ask permission to refer to a paper on Thyroid Tumors of the Bones by Dr. Kanosky of Kansas City. Extracts from this paper and case reports were read—showing that these foetal adenomata were often found in tumors of the thyroid where not suspected—that tumors found in distant parts often contained normal thyroid tissue and that the recurrence took place at times years after removal of tumors containing normal thyroid tissue.

Papillary carcinomata occurs, but not frequently. Malignant tumors developing in normal thyroid are very rare. There are some who say they never occur, but that there must always be pre-existing goitre. Balfour says—We have never seen a single instance of cancer developing in a normal gland. This fact parallels the low cancer incidence in other ductless glands. Malignant degeneration of goitre occurs most frequently in women (whether this is because goitre is more common in women I do not know)' most often about the menopause, and in both sexes between 40 and 60 years of age. Goitre showing signs of enlargement at the menopause should warrant removal. The development of cancer may be acute, sub-acute or latent. Symptoms of thyroid insufficiency are not common in malignant diseases, there is usually enough normal tissue to meet physiological requirements and, strangely, it has been said that malignant cells do not lose their ability to function properly.

Diagnosis.—The clinical diagnosis of cancer of the thyroid in early stages is impossible. The rate of growth of tumor alone being suggestive. In no other region of the body is malignancy so well concealed. Rapid increase in volume of a goitre which has been inactive, changes in consistency and lessened motility, with pressure effects on the trachea, the oesophagus, or laryngeal nerves, are all significant of malignant changes. Erosion of the tracheal wall or oesophagus and at times carotid vessels may

occur. Deaths have been reported from hemorrhage due to the latter cause. Involvement of cervical glands too may occur in this type of disease. Occasionally it will be difficult to determine microscopically the malignancy of certain growths. The thyroid may develop hyperplasia of its cellular elements simulating malignant degeneration.

The blood picture does not throw any light on diagnosis. Sarcomata represent less than 5 per cent. of malignant tumors, the most frequent types being round and spindle celled growths. Very occasionally sarcoma and carcinoma may be found in the same gland—so-called carcinoma-sarcomatodes. These growths (sarcoma) arise from the connective tissue of the gland—often in nodular goitre, where connective tissues may be abnormally developed. They grow rapidly, early become adherent to surrounding tissues—are soft in consistency, and friable and have a tendency to undergo necrosis or fatty degeneration.

Mixed tumors.—Osteo. chondroma-adenoma are found in elderly people and may take on malignant change. Dermoids and teratomata are exceedingly rare, but few cases being reported in literature. Sarcoma of thyroid may occur in early life but is usually seen between 50 and 60 years. In advanced age cell elements atrophy while connective tissue grows with energy.

Treatment.—There is but one or has been one treatment.—operation—and the earlier the better, before capsule is invaded, before glands are involved or veins thrombosed. Cures from operation for cancer of thyroid have been reported, but because of the tendency in the group of malignant adenoma to wide dissemination and in the carcinoma to early extension to adjacent tissue cures have not been common.

Goitre cases should be watched—the possibility of malignant change must always be kept in mind. When the clinical diagnosis of cancer of thyroid is certain, operative cure is rarely possible and operation in infiltrating, advanced cases when the capsule has been perforated and muscle and glands involved is attended by severe operative risk and almost certain recurrence. Encroachment on the trachea and oesophagus must always be borne in mind and the danger of tracheal collapse during and after operation considered. For this reason operation should be done under local anaesthesia.

Whether x-ray or radium will help or displace the knife is a question for the future to decide. Possibly the principal concern will be with the inoperative cases in which

great suffering and distress is being caused by pressure on the trachea or oesophagus or the involvement of the laryngeal nerves. When there is danger of asphyxiation from pressure Crile advises, under local anaesthesia, making collar incisions, transverse division of muscles and resuturing of the wound. When tracheal collapse occurs, tracheotomy may have to be done. Inanition from oesophageal obstruction may require tube feeding or gastrostomy to prolong life.

Occasionally where the gland is much involved in the carcinomatous process or after operative removal because of such, myxodema may result and thyroid extract may have to be given. Following operative treatment, immediate thorough x-ray treatment should be carried out.

Of 103 cases studied by Balfour during six years (Mayo's Clinic) it was found that the average number of years a normal growth in the thyroid preceding operation was 11.6 years, and he says this is proof positive of the advisability of early removal of developed thyroid nodule—that is removal of the precancerous condition—adenoma.

CARCINOMA OF THE BILE PAS-SAGES.*

By Jean F. Wolfs, M.D.,

Newark, N. J.

The irritative causation of cancer in the gall bladder seems to be well borne out by the frequency with which gall stones are formed in gall bladder, proving on examination to be the site of primary carcinoma. Various writers give the following percentages: Musser, 69; Flutter, 78; Winton, 81; Zenker, 91; Courvoisier, 91; Siegert, 95; Janowsky, 100; Deaver, 87. This gives an average of 86.5 per cent. for all cases reported.

That the occurrence of carcinoma does not cause the stones is well brought out by Beadles, who found only two gall bladders with stones in a series of 68 cases of secondary involvement by carcinoma. From an examination of the above figures we can deduce the fact that carcinoma of the gall bladder will occur much more frequently in women. This is proven by the statistics which show 80 per cent. in women. The greater frequency of occurrence is in the fundus. The neck and upper portion of the cystic duct come in the order named.

*Read at a meeting of St. Barnabas' Hospital Staff, Newark, December 27, 1923.

Schroeder states that eventually 14 per cent. of all cases of gall stones in the gall bladder, will result in cancer.

There are two forms in which primary cancer of the gall bladder is found, the most common one is an infiltrating growth of the wall, the second occurs as a cauliflower projection into the lumen. Both types metastasize rapidly into the liver by way of the lymphatics and by extension along the bile ducts. The columnar type forms the majority of cases. Cases of squamous cell carcinoma are reported.

Carcinoma of the bile ducts is no where near as frequent as carcinoma of the gall bladder. The ratio is generally given as one to six. Here again the evidence checks with the stone irritative cause of the disease. This point however is disputed, as papillomata are of more frequent occurrence in the hepatic and common ducts, and some writers are inclined to give degeneration of these papillomata the unenviable first place in causation of duct cancer. This argument is helped by the finding that stones occur in less than 50 per cent. of these cases. Mayo-Robson's view seems more rational. He considers that the stone which originally set up the irritation has either been passed or ulcerated its way into the duodenum. Another point worth bringing out is the fact that bile duct cancer, and we are speaking throughout of primary involvement, occurs more often in men, 61 per cent. This checks up with the fact that common duct stone occurs equally in the two sexes.

While the occurrence of cancer may take place at any point in the common, common hepatic, hepatic or cystic ducts, the greater proportion are found in the common duct, and two-thirds of these at the lower end. The second point in frequency is the junction of the common hepatic, cystic and common duct. The third in the common hepatic, fourth the cystic, fifth the right and left hepatic. It is well to remember that carcinoma developing near the papilla of Vater may be of intestinal, pancreatic or bile duct origin.

The diagnosis of gall bladder carcinoma, as in most abdominal and thoracic carcinoma, cannot be made in the early stages without exploratory operation. The invasion is so insidious and rapid that by the time a positive diagnosis is possible the case is inoperable, as far as any hope of cure is concerned. The symptoms are those of the associated cholelithiasis and cholecystitis. In a large series of cases Dr. W. J. Mayo has found 4 per cent. of carcinomatous gall blad-

ders in cases of cholecystectomy for stone and chronic infection. This would seem to be a very convincing argument for cholecystectomy versus cholecystostomy. However the statistics I have found, do not tell whether all of these cases occurred in gall bladders hopelessly useless from chronic inflammatory changes, or whether in some, there might have been an idea that it could probably be saved by drainage.

In Moynihan's great experience he knows of but one case of cancer following operation on the gall bladder. In a recent article by Darner giving the end results in 300 cases of gall stone and inflammation of the gall bladder treated by drainage alone (series by Cullen), there is no record of cancer of the gall bladder, although two cases developed cancer of the liver and two developed cancer of the pancreas. The diagnosis of bile duct carcinoma is generally possible until partial obstruction of the bile duct occurs. Then the fact that the jaundice is not intermittent serves to distinguish it from common duct stone.

Rolleston sums up the clinical picture of cancer of the biliary passage as follows: 1. Insidious onset, first symptom generally jaundice 2 acute onset of gastro-intestinal symptoms followed by jaundice, suggestive of ordinary catarrhal jaundice; 3 vague dyspeptic symptoms for some time preceding onset of obstructive jaundice; 4 sudden onset of colicky pain simulating impaction of stone.

The treatment is self evident and consists in prophylaxis. Early removal of stones before the gall bladder is damaged, demands an early diagnosis of cholelithiasis and cholecystitis.

Operative interference in beginning cancer of the gall bladder calls for its complete removal with the adjoining section of the liver. When the liver is already involved and when the lymphatics show involvement the hope of any operation is gone. Small growths of the common duct may be removed with short circuiting of the gall bladder into the intestine or stomach. Palliative treatment consists in the same operation. Radical operation in more extensive growths of the ducts, particularly at the duodenal end, have an enormous immediate mortality and the results in those who survive the operation does not seem to make the effort worth while.

Clinical Reports.

Gangrenous Diverticulitis of Cecum.

Drs. Harry G. MacDonald and Donald A. Curtis, Hackensack, N. J., reported the following case:

The patient, a man aged 30, white, married, gave negative family and past personal histories. The present complaint began four months ago with occasional pains in the right iliac fossa. These pains were mild, colicky at times, but often present merely as soreness. There were dyspeptic attacks, and occasionally a slight fulness in the lower right quadrant, four to six hours after eating. The pains were never accompanied by nausea, vomiting, diarrhoea, constipation, jaundice, fever, or urinary disturbances; they did not radiate, and seemed entirely independent of taking food, position, or condition of bowels. These vague disturbances worried the patient rather than cause him to actually feel sick and did not interfere with his usual occupation. About two weeks previous to operation the soreness became somewhat more severe though there was nothing to suggest to the man an acute illness. After trying various "home remedies" for some time he decided for the first, to visit a physician, and determine, in his words, "whether there was really any trouble."

Physical findings were negative as regards the head, neck, thorax, extremities, cardiovascular, and nervous systems. The patient was somewhat undernourished, but did not seem actually ill. Abdominal examination revealed a slight general tenderness over the entire right side, more marked over McBurney's Point, some rigidity, but no mass distention. Temperature was then 99, pulse 90, and respiration normal. The urine was negative, and blood showed a W. B. C. count of 12,000, and a poly count of 80. X-ray was not utilized because of patient's financial status. A diagnosis was made of sub-acute appendicitis, and operation advised.

Laparotomy was performed two days later, October 5th, 1923, at the Paterson General Hospital, by the lower right rectus incision. Peritoneum appeared normal, and there was no free pus or fluid. On locating the cecum, a mass was felt, to the right and posteriorly, which was adherent to the urinary bladder at its distal end, and which seemed to the touch, an enormously enlarged appendix. As adhesions were loosened, the mass freed and exposed, it was found to be a diverticulum of small gut, about six inches in length. The diverticulum was gangrenous to within an inch of its proximal end; the free end was ruptured, exuding pus with a typical *Colon Bacillus* odor. The appendix was elongated, slightly inflamed, and connected to the under surface of the diverticulum by a dense fold of tissue, containing several enlarged vessels. The usual appendicular mesentery was attached to the opposite side of the appendix.

The appendix was removed from its cecal attachment in the usual manner, but left adherent to the diverticulum. The diverticulum was ligated about half an inch from its base, and removed en masse. Each coat of the stump was closed with linen thread, and the whole inverted and purse-stringed. The peritoneal cavity was drained with one large

**DO NOT FAIL TO ATTEND YOUR
COUNTY SOCIETY'S MEETINGS**

garette drain, for which, after two days a rubber tube was substituted. The wound discharged a large amount of pus for two weeks, at the end of which time drains were discontinued, and the patient made an uneventful recovery.

Primary Actinomycosis of Skin.—Dr. M. J. Jaskin, in the A. M. A., May 6, reports this case:

H. M., aged 35, a farmer and trapper, presented himself, May 3, 1919, with a lesion of the left hand. He had been trapping, and the lesion commenced a week before. Thinking it a boil, he painted it with iodine. The patient was healthy, with no subjective symptoms and all findings negative except the left hand. The temperature was normal. The leukocyte count was normal. The Wassermann reaction was negative. On the left hand was a lesion covering the wrist and entire dorsum of the hand, and extending onto the dorsal surface of the fingers. The skin was purplish, with numerous small sinus and firm nodules. One of the nodules was incised and a minute droplet of pus expressed. Microscopic examination disclosed the fungus. The nodules were incised and the lesion curetted. Administration of potassium iodid was instituted, and boric acid dressings were applied. At the end of ten days the lesion showed no improvement and had increased in extent. May 13, the Dakin's solution as outlined above was used, and immediate improvement began. In one week the lesion had been reduced in extent by one-half. By June, two weeks after the institution of the treatment with Dakin's solution, the lesion was healed, leaving no scar. There has been no return to date.

County Medical Societies' Reports

BERGEN COUNTY.

Dr. Frederick S. Hallett, Reporter.

The February meeting of the Bergen County Medical Society was held at the Hackensack Hospital, February 12th, 8.30 P. M. The president, Dr. G. L. Edwards, presided. About 40 members were present and several guests.

The following doctors were elected to membership: Drs. Charles H. Brooks, Rutherford, and T. M. Walsh, Hasbrouck Heights.

Scientific program for the evening: Dr. Milton J. Raisbeck, special lecturer on cardiology, Flower Hospital, New York City. "The Practical Use of the Sphygmomanometer," illustrated with projection lantern. The doctor presented his subject in a most instructive and interesting manner. The value of the sphygmomanometer as an aid to diagnosis and prognosis in cardiac disease was a revelation to many of us.

CAMDEN COUNTY.

F. William Shafer, M. D., Reporter.

The regular meeting of the Camden County Medical Society was held in the City Dispensary building, Camden, Feb. 12th at 3 P. M. Dr. J. Edgar Howard, president in the chair.

Dr. A. H. Lippincott, chairman of the Welfare Committee, reported on the six bills that are before the State Legislature. His report was accepted and the secretary was in-

structed to write to the Senator and three Assemblymen in favor of these bills:

A new member, Dr. Maurice E. Baker, was introduced and the following new members were elected: Drs. Cedric E. Filkins, Oaklyn; Lavinia E. Clement, Haddonfield; Joseph C. Lovett, superintendent Municipal Hospital, and Gordon F. West, Camden.

Dr. Roland I. Haines resigned as he has moved to Miami, Florida.

On motion, ten members were dropped for non-payment of dues. The following scientific program was then observed: "Some Facts Relative to Cancer," Dr. W. J. Barrett; "Cancer of Skin with Slides," Dr. H. B. Decker; "Cancer of the Gastro-Intestinal Tract," Dr. J. Lynn Mahoffey; "Cancer of the Genito-urinary Tract," Dr. A. Haines Lippincott; "Cancer Histology," with slides, Dr. D. F. Bentley, Jr.; "Uterine Cancer," Dr. Thomas B. Lee. The papers were limited to ten minutes each.

CAPE MAY COUNTY.

Eugene Way, M.D., Reporter.

The fortieth annual meeting of the Cape May County Medical Society was held in the Court House at Cape May Court House, on December 27, 1923. The president, Col. Charles M. Gandy presided. Members present: Gandy, C. W. Way, J. Way, E. Way, Tomlin, Haines, Hughes. Drs. Mullard Cryder and A. C. Moon were elected members of the society and Dr. Humphrey Swain of Goshen, a graduate of 1800, was elected an honorary member.

President Gandy then introduced Miss Ellen S. Brinton of the Educational Service Department of Abbott's Aldernery Milk Dairies, who gave a talk on milk, illustrating the lecture with motion pictures. Three films being shown: One on pasteurizing milk; one on certified milk and one on the manufacture of ice cream.

Miss Brinton proved to be a pleasing lecturer of charming personality and was voted the thanks of the society. The president then introduced Mr. Ernest D. Easton, executive secretary of the New Jersey Tuberculosis League, who outlined the objects of the League and advocated the annual "birthday inspection" of everyone in the State. He further showed the great decrease in the number of deaths from tuberculosis since the inauguration of the League in the adoption of its principles. He recommended a tuberculous clinic in Cape May County, stating that funds would be available to conduct it for at least one year. The society after discussion voted to support the objects of the League and to support the clinics in every way possible.

This following officers were then elected for the ensuing year: President, Col. Charles M. Gandy, Ocean View; vice-president, George F. Dandois, Wildwood; secretary and reporter, Eugene Way, Dennisville; treasurer, H. H. Tomlin, Wildwood.

Committee on Public Health, Legislation and Welfare: Dr. Julius Way, Cape May Court House; Dr. Millard Cryder, Cape May Court House; Dr. W. A. Lake, Erma.

Delegate to State Society: Millard Cryder. Alternate: George F. Dandois.

Place of next meeting: Egg Harbor Inn, Busly's Point. (Ladies' Day.)

HUDSON COUNTY.

Wm. Freile, M.D., F.A.C.S., Reporter

The society met on February 5th at the City Hospital, Jersey City, President Kelley in the chair. Dr. E. J. Luippold, chairman of the annual dinner committee, spoken of the rate at which tickets were going, and presaged the largest gathering in the history of the society.

President, Dr. C. B. Kelley, mentioned that there was not really any legislative committee functioning at present, notwithstanding the provision made in the By-laws. He had taken it upon himself to appoint such a body, had made Dr. Pollak chairman, and he with several members had been to Trenton.

Dr. Pollak, by request, stated he had gone to Trenton with Dr. Londrigan, and he had met there Dr. Quigley of the State Welfare Committee. Dr. Pollak then detailed his experience at the conference of the State Board of Medical Examiners and State Welfare Committee. He felt that there was produced a clouding in the minds of the legislators, by the lack of unanimity between the State Board of Medical Examiners and the Welfare Committee. This was illustrated in the bill opposed by the Welfare Committee, but nevertheless introduced, making it compulsory for physicians to register annually with the State Board of Medical Examiners and pay a \$3.00 fee. And so with another bill sponsoring colleges that shall be permitted to graduate candidates for medicine. In brief, Dr. Pollak did not feel that Dr. McAlister, of the State Board of Medical Examiners, had demonstrated that he was looking toward the welfare and interest of the medical practitioners.

Dr. A. W. Oestmann preferred charges against a member; this was delivered in writing to the secretary and referred to the board of censors.

Dr. Quigley gave notice to the By-laws to change "Public Health and Legislative Committee" to "Welfare"; and instead of election, to be appointed by the president annually.

Dr. H. H. Brinkerhoff stated that the By-laws had been last approved in 1914, and moved for a committee to revise the Constitution and By-laws to bring them up-to-date.

Nine new members were elected, and several applications referred to the censors.

Dr. S. A. Cosgrove, chairman of the Building Committee, detailed the work done; stated that all the necessary notices and legalities had been complied with; that the incorporation of the society would be consummated on the 19th inst., and that some definite action would be forthcoming from the site committee in a week.

Prof. Francis Carter Wood, Director of the institute of Cancer Research, Columbia University, New York, gave an informal talk to fellow practitioners, on "The Present Situation in the Therapeutics of Cancer." He said: Any discussion of the modern treatment of cancer should be preceded by classification of the disease as it presents itself clinically, in order to determine the proportion of patients who are in operable condition. Those who are inoperable are of a necessity unsuitable for surgery and must be treated by other methods. Of every thousand patients suffering from

cancer who enter any large hospital, only about 20% are operable. In other words, some 80% are, on admission, hopeless and their condition can only be palliated for a time by the use of radiation or other methods. Of those who are supposed to be operable, from clinical examinations, at least one half will be found at the time of operation to have some extensive involvement by the growth which could not be discovered by a mere physical examination, so that they are also hopeless. Of the remaining 10% scarcely one half survive for three years, owing to undiscoverable metastases involving different organs of the bony system. Thus no more than 5% of the cancer patients entering the hospitals survive the disease with which they are afflicted.

These statistics are perhaps somewhat inaccurate because patients with superficial cancer are usually treated by the dermatologists either privately or at the clinics and do not come for treatment to the general hospitals. Such skin cancers, however, form only about 3% of the total number causing death in the United States. Therefore their cure, assuming that it is possible in every case, will not alter very greatly the percentage as given.

These figures are from highly intelligent communities. In the country districts and in the large manufacturing towns the number of operable patients is still smaller. It is very doubtful therefore that even 1% of the cancer cases in the United States present themselves in time for a definite cure. This deplorable condition is due to two causes. One, the ignorance of the public concerning the nature of the disease; the other, the ignorance of many practitioners of medicine concerning the methods of diagnosis and the necessity for prompt treatment. A large number of patients also fall into the hands of quacks and are permitted to go with practically no effective treatment until the disease is hopeless. But this is merely a phase of the ignorance of the public concerning the difference between the quack and a competent physician.

When the typographical localization of the tumors is considered, several important facts become obvious. For example, cancer of the lip is easily diagnosed and is frequently operable with permanent cure. Cancer of the breast is also an extremely favorable site, in which about 50% of the patients admitted to hospitals are operable. And the permanent cures in such patients is about 30% of those operated upon, or 15% of all breast tumors. All of the external cancers are far more favorable than the internal. Of the latter a large proportion are always hopeless. Especially is this true of cancer of the stomach which forms about 50% of the cases of cancer occurring in the population. Very few of these patients ever come in time for a curative operation. Though collected series of cases have shown a permanent cure in from 10 to 20% of the cases operated upon, most of such large statistical collections are misleading as they rarely report the total number of cases observed, that is, those who are not treated because they were inoperable but only the ones that were operable.

In a recent collection, for example, out of some 15,200 cases of cancer which were op-

erated upon and observed for three years or more, some 25% remained well. This is evidently much too high, and no mention was made of the vast number of people who were rejected primarily because they were wholly inoperable. Operability also is a matter of personal opinion. For example, in the same collection it is stated that 60% of cancers of the bladder were operable, yet the three years' cures were only 2.4%, while of cancer of the prostate, it is stated that 36% were operable and 6.8% survived over three years. This casts some doubt on the diagnosis of these cases, because carcinoma of the prostate is almost always inoperable. On the other hand, carcinoma of the bladder offers, in a good many instances, a fair opportunity to remove the entire growth. Some surgeons reporting in selected series as high as 20% of three year cures. If we return then to our original figures that only 20% of the patients entering the larger hospitals were operable, and an optimistic statement of the results does not offer figures greater than 25% of five year cures, our original statement of not more than five out of a hundred of those entering a hospital with cancer are curable is made evident. And this despite all the efforts which have been made in this country and in Europe to disseminate knowledge concerning the importance of early diagnosis and early treatment.

This survey of the statistical situation in regard to cancer is sufficient to convince the most skeptical that it is no time for cheerfulness or easy optimism. The situation is indeed grave, as the census figures recorded deaths from cancer are increasing annually in this country, showing that the effectiveness of diagnosing cancer is increasing rapidly, although under ordinary conditions of country practice about half the deaths due to cancer are not recognized, but that our therapeutic procedures are not in any way making adequate headway against the general death rate from this disease.

Granting all this, what should we do with a patient who presents himself in an operable condition? My own opinion, expressed years ago, and which I have seen reason to alter, despite much criticism, is that all operable malignant tumors should be removed by surgical means. A host of dermatologists will arise and say skin cancers can be absolutely cured by radium, freezing, scraping, caustics, and so forth. This is quite true in a certain number of instances, but even those of the largest experience, such as McKee, acknowledge that there still remain 10 per cent. of carcinomata of the face which are not cured by radiation, even in his skillful hands. This corresponds to about the number of those which contain squamous cells, for basal cell tumors, both clinically and microscopically may contain a few squamous cells, either scattered or as pearl-like masses. These tumors require a very much larger dose of radiation to affect them, twice or three times as much as that of the ordinary basal cell epithelioma. As a clinical separation is impossible, and as a transient cure by radiation is not at all infrequent, the patient usually disappears, and is never seen again. But as the tumor may recur years afterwards, the

fairer method to the patient is to remove the tumor completely when first seen, after which removal no recurrence will ever take place. Some prefer cautery; some prefer the knife. The after results are the same. In other words, if, in order to make a diagnosis of the nature of the tumor you have to cut into it with the knife, to get a piece out, why not continue the operation and cut out the whole tumor?

There is an enormous amount of rubbish talked about the fact that patients fear surgery and prefer radiation. I never have seen a patient whose intelligence approached that of a twelve year old child who, when shown the facts, would not readily accede to any necessary surgery. My reason for preferring surgery to radiation, caustics, the cautery, freezing, and so forth, is simply that I have seen more recurrences follow these methods of treatment than I have following surgery. I have seen disastrous results follow the freezing of pigmented moles, and the same is true in a number of instances of treatment of moles by radiation. Sometimes the generalization of a melanoma did not take place for several years. In one terrible case of a man who had a mole on his back which had been "cured" by radium some four or five years previously, hardly a square inch of the man's body was free from black melanotic tumors. I have also seen a number of recurrences of cancer of the lip years after they were "cured" by radium, and a large number of the basal-squamous mixed types recurring two, three, four or five years after complete clinical disappearance following treatment by radium or by x-ray,—not by quacks, but by some of the leading institutions in the City of New York. Within a few days I have seen a man whose epithelioma of the lip recurred thirteen years after it was "cured" by radium. After freezing with carbon dioxide snow I have seen a large number of recurrences of various types of skin tumor, one as late as eight years afterward. The same is true of caustic, and of the cautery applied directly to the tumor itself to burn it out. You may burn out most of the tumor, but if you leave a single live cell entangled in the scar tissue, recurrence may take place. In operable cases, therefore, nothing replaces good, clean surgery. The scarring is minimal; the danger is slight, and the results are admirable, and leave nothing to be desired.

The minute however the patient passes the borderline between the operable and the inoperable, that patient should be considered as belonging not entirely to the surgeon, but to the surgeon in combination with the radiotherapist. Meddlesome surgery on inoperable cases is just as bad as meddlesome x-ray or radium. There are many inoperable tumors in which surgery is indicated, for instance, carcinoma of the pylorus, in which nothing is more effective than a gastroenterostomy, which sometimes gives a patient three to five years of health. A colostomy is often followed by five and sometimes six or seven years of apparent health. But to remove one cancerous breast and leave another; partially to excise a tumor of the tongue or lip, leaving the nodes of the neck, is almost worse than malpractice, and yet it is the com-

monest thing to see these patients upon whom these very practices have been inflicted.

Many of the surgeons who do such imperfect operations send their patients to the x-ray man with the request that he cure them, and is apt to be somewhat indignant if he gets the honest reply that radium and x-ray will not cure inoperable cancer. For the situation, which we might as well face, is that radium and x-ray do not cure cancer of the highly malignant type except in a minute fraction of the cases. We are not talking about the basal cell tumors of the face; I grant you that 90 per cent. of them can be permanently cured by radiation, and therefore you may use it, even though in my own opinion surgery is better. I am referring to the highly malignant types of tumors. Beautiful statistics are published of 30, 40 and 50 per cent. three-year cures of cancer of the breast with radiation. It was the fashion in Germany some time ago to report large series of carcinomata of the cervix cured by radiation, or, and in this country, of the tongue, lip, or tonsil and so forth. This was the time of optimistic reports regarding the extraordinary therapeutic value of radiation. On the other hand, Holfelder of Frankfurt, told me about a year ago that he had never cured a single case of carcinoma, though he explained that he saw no gynecological material. Holtzknecht, Haeberstadter, and other German radiologists of large experience have begun to protest against the extravagant and wholly unsupported statements of successful treatment by radiation. Recently Doderlein has collected all his material, and states that he is greatly disappointed in the result. The early temporary improvements had led him to hope that the results would be permanent. Gradually it is being acknowledged that the amount of radiation required to kill cancer is nearly or quite equal to that dose which will destroy many healthy cells. In other words, the old idea of the excessive susceptibility of the tumor cell as compared to the normal has had to be abandoned, and we realize that while many tumor cells are susceptible and it is very easy to kill 90 per cent. of the cells of a tumor, the remaining 10 per cent. are difficult, and in most instances impossible to destroy. They may be lodged in the connective tissue where their growth activities are somewhat restrained, but sooner or later they escape into a more favorable soil and begin to propagate their kind. We see no evidence of any destructive action of the health tissues on tumor cells. This has been much talked about in a very loose way, yet rests upon no scientific foundation. If cancer is to be cured by radiation, the individual cells will have to be killed.

For that reason many have turned to the extremely high local doses with radium, using five or ten erythema doses, and completely destroying the tumor and the normal tissue in its environs. A cure can certainly be produced by this method. I was amused once in hearing a physician say that he cured many epitheliomata of the lip I asked him what his dose was, and he explained it was about six erythemata. He acknowledged that the scarring was a little bad after such a dose, but that it worked. I inquired how he knew whether the glands in the neck were invaded or not. He said that

only a few of his cases had shown any return in the neck, and were then, of course, hopeless. He could do nothing with such a lesion. Nevertheless patients might have been cured if the nodes had been excised at the same time he was employing x-ray as a caustic to the lip, but a far better plan would have been to have excised the nodes and the lip at the same time. This caustic action of radium is very obviously useful in carcinoma of the cervix, which is the chief field in which real cures may be expected. What proportion of these patients will survive the five-year period we do not as yet know. Very insufficient statistical material is at present available. At present the results are in most clinics less favorable than surgery in the operable groups.

The difficulty with radiation is that it implies a knowledge of the susceptibility of the tumor, that is, that the tumor will die with a given dose, and no one can state that, not even with the microscope. Surgery makes no such assumption, but cuts the lump out. Therefore every radium treatment is an experiment, and that is why radiation should not be used on primary operable malignant tumors.

But if we cease to try to "cure" the inoperable cancers, which form the larger part of those we treat, and are willing to palliate we can obtain astounding good results in many instances. It is true that cancer of the stomach, liver and pancreas are practically not at all affected by radiation, and that tumors of the lung, the kidney, thyroid, buccal cavity, etc., but rarely yield in an effective way to any dose which we can apply, but by careful application of well-judged x-ray or radium, filtration, dosage, it is possible often to prolong life for a considerable period in comfort and in very rare instances, produce, an apparent cure.

Inoperable tumors of the larynx, pharynx, lip and tongue, can be treated by insertion of radium needles. The nodes in the neck, if involved, should be excised, as everyone now knows that cancer in the cervical lymph nodes cannot be destroyed by radiation. The tendency has been, however, to attempt too much. Patients suffer agony far greater than that following surgery from radium burns, and life, even though prolonged a short time, is hardly worth possessing. With smaller doses and long periods, such as Regaud has recommended, we may get no cures, but we are likely to obtain far better palliation. The same is true of x-ray. Metastatic nodules of carcinoma of sarcoma in the chest can be reduced in size; cough can be relieved, and the pain due to spinal cord and nerve trunk involvements is often ameliorated. Tumors of the lower abdomen, ovaries, bladder, prostate, kidneys, and the embryomata of the testicle often yield temporarily with great relief and well-being of the patient. Lymphosarcomata may yield remarkably or may be highly resistant. Some of the bone sarcomata are highly resistant; others seem quite susceptible to radiation, but sooner or later all those that originally possessed a malignant tumor are likely to show evidences of recurrence, despite the largest quantities of x-ray or radium that we may pour into the affected region. In the last analysis our radiation

methods have disappointed us as cures, but have astonished us as palliatives.

No case can be pre-judged. Take for example three recurring nodules of the chest in three different patients whose carcinomata of the breast resembled each other microscopically: One set of nodules may disappear; the second will remain stationery; and the third will grow under the same dose of radiation. There is no carcinoma and no sarcoma dose. It would have been better for patients with cancer if this loosely used term had never been made in Germany.

What is to be done? In the first place every effort should be made by physicians like yourselves to educate your public and to help your colleagues who may not have had the benefits of education which you possess in the way of learning and in the importance of the early diagnosis of cancer. I grant you that this is extremely difficult. All the improvements of modern diagnostic equipment may fail, and the patient die of cancer with the growth unsuspected. Every month or so in my own hospital we autopsy such a case, not a symptom of cancer ever having been given by the patient. On the other hand, there are many thousands of people, perhaps the greater proportion of the suffers with cancer, that show unmistakable symptoms at a fairly early stage, and these people are allowed to drift without a diagnosis for months or years.

In our own community the lay public is better educated to the dangers of cancer and the necessity of prompt treatment than is the profession, and the same is true of metropolitan Boston. Delays have not been due to the patient, but rather to the physicians who first saw them. The best way in which this can be remedied is for all of you to assist in spreading information and by backing up in every possible way the activities of the American Society for the Control of Cancer. That organization is going ahead in a sound and scientific manner, prepared to offer to both patients and physicians such information concerning cancer as exists in print, though much of it unfortunately is not convenient or available. Each physician can do a great deal among his own small clientele by personal advise, suggestion, recommendation of annual careful examination of all persons after the age of forty. Many early carcinomata not only can be, but have been discovered in just this way. The next thing is to see that if a patient has a suspicion of a carcinoma that he is referred to the man most competent to complete the diagnosis, and then to the surgeon most competent to remove the growth and its possible extension. I do not agree that any surgeon can operate upon a cancer. I think it should be one of the most limited of specialists, to be entered upon only by a few highly equipped men with extensive anatomical and pathological knowledge, and possessed of a great degree of patience and operative skill. He also should have indomitable courage, for successes are few. Too many of our colleagues take a pride in "whipping off" a breast in twenty minutes, or in attempting to clear the side of the neck of all possible nodes in an hour, neglecting to remember that epithelioma of the lip metastases to both

sides very frequently. Then there is often a lack of preparation of the patient for difficult and dangerous operations, especially on the bladder, rectum and mouth. Much is still to be learned about the best type of anesthesia in a given condition, as cancer is a transportable disease, and as there are always a few days to spare in which the patient can reach the best available surgeon. I hope and believe that the future will see large institutions primarily devoted to cancer surgery in which a corps of well equipped men, will each work on the special region in which he is most interested. The glamour which has hung over surgery since the discovery of asepsis is fading. Everybody knows that the recent graduate from a big hospital can operate about as well as his chief. Everybody knows that you can go to a hospital and can get just as good surgery for \$100 as for \$1,000. Everybody is beginning to learn that surgery is an art requiring certain judgment and mechanical skill, but that there is a vast difference between mere surgery, and that of the highest skill. Hardly a day goes by that in the large material that comes to my x-ray clinic I do not see some unfortunate patient who, if the facts were known, should get a judgment for a large amount of damages against the so-called surgeon who has committed a crime in operating, in doing partial excisions and unnecessary removals, because incomplete, of lip, tongue, and other tumors. All this is known to all of you and will be corrected in time, but we can assist in such correction by seeing that our patients go only to such men who can "deliver the goods." A single hospital of 400 beds in the New York district would take care of all the patients therein. Such a hospital with ten or twelve especially skilled surgeons attached could handle all our material, make money, and achieve the saving of many lives. This is what I look forward to in the future.

I have spoken of the operable cases and what we should do with these. The inoperables deserve just as much care. They form 80 per cent. of all the cancer cases we see. They are the most pitiful and most unfortunate people in the world. Death is inevitable for most of them. They should therefore, have all the care and kindness that we can give them. They should be referred to careful radiotherapeutic institutions or individuals who are known to be competent and honest. There is no form of quackery in which there is more over-charging and more futile radium and x-ray treatment than is practiced by physicians who are working in this line. Many patients with large, perfectly hopeless tumors are treated with small quantities of radium at an enormous cost in proportion to their ability to pay. After the money is gone, these people become a care to their municipality. But many of these unfortunates might, if properly treated return to your offices year after year with good color, gain in weight, doing their work, and grateful for the respite which radiation has given. From this aspect these are the two most important therapeutic agents for the treatment of inoperable cancer medicine. Everything else is a waste of time that have been discovered in the history of vaccines, sera, tonics, stimulants, diet, are all

pure quackery and should be avoided by every self-respecting physician.

All this is a gloomy picture, but every day surgery is improving, advances are being made in x-ray and radium treatment which warrant the hope that some day a certain number of cures of the inoperables may really be obtained and more benefit to those who cannot be cured.

But hope never cures cancer. We must all together,—surgeon, physician, pathologist and iodio therapists—struggle to learn more of cancer and thereby to do fore for the cancer patient.

MONMOUTH COUNTY.

Harvey S. Brown, M.D., Reporter.

The regular meeting of the Monmouth County Society was held at the Metropolitan Hotel, Asbury Park, on Tuesday, January 29, at 8.30 P. M. Dr. M. W. Reddan of Trenton read a paper on "Diagnosis and Treatment of Head Injuries." Discussion by Dr. Slocum and Dr. Garrison. Dr. J. A. Fisher of Asbury Park read a paper on "Iritis," which was discussed by Dr. Upham. Open discussion of these papers by members of the society followed and a profitable and enjoyable evening resulted. Twenty-five members were present.

February Meeting.

The February meeting of the Monmouth County Medical Society was held at the Elks' Home, Garfield avenue, Long Branch, on Tuesday evening, February 26, 1924.

Dr. J. J. King of New York gave an address with lantern slides on "The Removal of the Tonsils," and Dr. Harvey S. Brown presented a paper on "Protect the Child from Diphtheria." The paper was discussed by Mr. Wm. H. MacDonald, district health officer of Monmouth County, and by Dr. Prout of Asbury Park. Dr. G. V. V. Warner for two years president of the society was presented with a suitably inscribed gold fountain pen and at the close all enjoyed a banquet served under the direction of Benj. Weber of the Golden Pheasant Restaurant, in the Elk's dining-room. Twenty-six members were present.

PASSAIC COUNTY.

Louis G. Shapiro, M. D., Sec'y.

The February meeting of the Passaic County Medical Society was held in the Chamber of Commerce rooms on Thursday, February 14th. Dr. Ryan, the president, called the meeting to order at 9 P. M. There were fifty members present. The regular order of business was suspended so that the scientific program could be taken up immediately.

Dr. John C. McCoy presented a case of urinary fistula in a young man, that had resulted from operation for a ureteral calculus, embedded in the wall of the bladder. Several subsequent operations had failed to cure the fistula. The last fistulous tract was shown by bismuth injection and x-ray, to extend through the gluteal region. An extensive resection was done and for the past several weeks there had been no signs of recurrence of the fistula.

The talk of the evening was given by Dr. Edward F. Kilbane of New York on "Some Unusual Urological Conditions," and center-

ed about the demonstration by lantern slides of x-ray pictures, and pictures of surgical specimens from these cases. Dr. Kilbane presented a wealth of very interesting and instructive material. Drs. John Carlisle and John C. McCoy discussed Dr. Kilbane's address.

A vote of thanks was extended Dr. Kilbane for his instructive address.

SALEM COUNTY.

William H. James, M. D., Reporter.

The February meeting of the Salem County Medical Society was held at the Memorial Hospital Wednesday, February 13th, at 2 o'clock P. M. The meeting was called to order by Dr. Franklin H. Church, the president.

The reports of the various legislative committees were read and at the conclusion of the regular business of the society. Dr. Russell Richardson of Philadelphia gave a very interesting talk, taking for his subject "Diabetes and Insulin."

Among other things the doctor said that diet is a very important thing to consider and that insulin was a dangerous remedy unless intelligently prescribed. At the conclusion of the discussion of the paper, the doctor was given a rising vote of thanks.

The society holds meetings every second month during the year and the interest seems to be growing. Those present were Drs. Church, Davis, Smith, Hires, Sherron and Green from Salem; Drs. Husted and Miller from Woodstown; Dr. Davies from Elmer; Dr. Downs from Swedesboro, and Drs. Glendon and Moore from Bridgeton.

At the close of the meeting, to the surprise of most of the members present, we were invited to partake of a platter luncheon, through the courtesy of Miss Harris, the superintendent, and Mrs. Lawrence, the matron, of the hospital. To say it was thoroughly enjoyed by every one present, would be putting it mildly. The next meeting will be held April 9th, 1924, at 2 P. M., at the Memorial Hospital, Salem, N. J.

Local Medical Societies

Hospital Staff of St. Barnabas.

A special meeting of the medical staff was held in the hospital on December 27th, 1923.

The special subject for discussion was "Cancer; Its Early Diagnosis and the Operable and Inoperable Conditions of a Case."

Papers were presented by Drs. E. J. Ill, J. F. Wolfs, J. F. Hagerty and J. W. Gray.

Dr. Edward J. Ill called attention to the rare carcinoma of the vulva. It is always malignant and usually occurs in the form of an epithelioma. It generally makes its appearance late in life and develops rapidly. Early operation offers a good chance for cure. Cancer occurring within the cervical canal is as a rule incurable by operation; whereas if it develops in the vaginal portion of the cervix, the prognosis is good provided an early and complete operation is performed. As a rule a cure can be expected following early operation for cancer of the body of the uterus. Metastases in such cases are rare.

Cancers of the ovary vary considerably in

malignancy, certain forms are very malignant. Here again early operation offers the best hope for cure. Regarding early signs of cancer, Dr. Ill called attention to a bloody flow occurring after intercourse which may in many cases be observed before the watery discharge appears. Tumors of the breast are frequently watched over too long a period and allowed to progress to a hopeless stage. In case of doubt it is always wiser to refer the case to a man of experience.

That cancer is not an infectious diseases, Dr. Ill made it clear by calling attention to a series of experiments made under his direction during the year 1910. The results were published in the *Journal of the American Medical Association*, August 17th, 1912, Vol. LIX pp. 497-502.

(The papers presented by Drs. Wolfs, Hagerty and Gray will be found under Original Articles.—Editor.)

Bayonne Medical Society.

Martin I. Marshak, M.D., Reporter.

The Bayonne Medical Society met at the Elks' Club on Monday, February 18, Dr. S. Chayes presiding.

Dr. W. W. Brooke reported a case of chronic peritonitis in an old alcoholic, due to seepage from a duodenal ulcer. Operation performed for an acute rupture of the ulcer showed the entire upper half of the abdomen involved in the picture of the chronic peritonitis and the lower half free from any chronic disease, but showing an acute lesion.

Dr. G. W. Sexsmith reported a case of fracture of the neck of the femur in a girl of 18 years, which had been treated by a chiropractor with a resulting poor position and marked shortening.

Dr. J. L. Rosenstein of Jersey City read a paper on "Retropharyngeal Abscess." He stated that this was an acute condition invariably due to infection and following nasopharyngitis, or one of the acute exanthemata. The symptoms consist of fever, difficult deglutition, enlarged glands at the angle of the jaw, slight retraction of the head, extreme fretfulness, and a muffled, metallic and nasal quality to the cry. The breathing is both noisy and rattling. There is a red fluctuating mass in the posterior pharynx which can be easily palpated. He felt that this mass should be incised with the patient in a prone position with the head held low. He summarized as follows. "1. Retropharyngeal abscess is seen in children at the age of three months to three years; the lymph nodes being present in the posterior pharynx at this period of life; 2. Any seat of the posterior pharynx may be the location of an abscess; 3. It is always the result of bacterial invasion; 4. Its diagnosis depends mainly on palpation with the finger of a fluctuating mass in the posterior pharynx; 5. The treatment is operative procedure immediately upon its recognition."

The discussion brought out that these cases are occasionally intubated, that it is a winter condition, opening the mouth gag too widely prevented swallowing so that if some pus does go down it is aspirated and that the condition is infrequently found as compared to ten years ago. Koplic and others advise open-

ing the abscess with the patient in the sitting position. A great many authors still claim that the condition is an idiopathic one. Drs. Thum, Malloy, Larkey, Woodruff, Sexsmith and Rosenstein took part in the discussion.

Medical Staff St. Michael's Hospital.

The February meeting of the Medical Staff of St. Michael's Hospital was held Thursday, February 7th, at 12 o'clock noon. The subject for discussion at this meeting was: "Cancer—Its Early Diagnosis." Five minute papers were read, followed by a general discussion. Dr. Chas. E. Teeter, president of the Medical Board, presided. Papers were read by the following: Dr. Edward J. Ill, "Cancer of the Uterus"; Dr. John F. Hagerty, "Cancer of the Breast"; Dr. George Blackburne, "Cancer of the Gastro-Intestinal Tract"; Dr. Edgar A. Ill, "Cancer of the Prostate and Kidney"; Dr. William Petry, "Cancer of the Lung, Mediastinum and Pleura"; Dr. William Keim, "Cancer of the Tongue and Tonsil."

Medical Staff of Jersey City Hospital.

A regular meeting of the Medical Staff of the Jersey City Hospital was held in the hospital February 14, 1924, Dr. S. A. Cosgrove, presiding.

Present: Doctors Cosgrove, Street, Koppel, Chambers, Larkey, Jaffin, Nicholson, J. Sullivan, Rieman, Barbarito, St. George, Daley, Doody, Hernandez, Hasking, Butler, Barrett, Singer, Rietnauer, Duffy, Barishaw, Frundt, Waters and the internes.

Dr. Cosgrove announced that he had been requested by the medical director to bring before the members of the staff, the question of discussing at these medical conferences, the hospital deaths occurring during the month. He pointed out that the American College of Surgeons lays great stress on this particular subject and stated as his belief, that a great deal of general information might be furnished by the practice. After a general discussion of the subject, the matter was referred to the programme committee to consider a feasible plan for utilizing the deaths in the hospital for a clinical study and presentation at these conferences.

Dr. T. R. Chambers reported two cases, one of purulent sphenoid sinus with atheroma of cerebral vessels, and the other of purulent frontal sinus with sub and extradural abscesses. The doctor read a very complete history in each case and discussed in detail, the procedure followed by him. Both patients died at the hospital, and autopsies were performed by Dr. St. George. These autopsy reports were also read. Dr. Chambers stressed the point that in cases of this kind it is not good policy to rely to any great extent upon x-ray findings as they are very apt to be misleading as these two cases and others during his past experience would seem to prove.

Dr. D. B. Street reported a case of hemorrhage into the pituitary. This case presented symptoms and findings consistent with a pituitary tumor. X-ray plate showed calcification in and near the pituitary glands. Spinal fluid gave extremely interesting findings of a non-infected meningitis, with a very high cell count and evidence of recent hemorrhage into the cerebro spinal fluid. Case was tended by

progressive improvement up to the time of leaving the hospital. Dr. E. A. Waters discussed the case.

Dr. S. A. Cosgrove exhibited a case of a II. Gravidia who was admitted at seventh month in severe eclampsia. Upon operation, it was found that she had two uteri, right and left, each having respectively one tube, one round ligament and one ovary in their normal relation to its distal side. The left uterus had a cervix protruding into the single vagina in normal relationship thereto; the right uterus had no cervix, and no demonstrable connection with the vagina. It was the latter uterus, however, which contained a normally developed seven months' fetus. This most unusual anomaly will be reported more fully in the literature at a later time.

The paper of the evening, the title of which was "Basal Metabolism and Its Clinical Application," was given by Dr. Eugene F. Du Bois, associate professor of medicine at Cornell University, and director of the second division at Bellevue Hospital. Dr. DuBois took up the fundamental consideration of basal metabolism work and explained the theoretical mechanism and value of the test. He went into a detailed account of the clinical application of the method, discussing not only its applications, but its source of air and its limitations. The paper was an admirable resume of the basic facts of basal metabolism and its more important clinical aspects.

Dr. Cosgrove, the chairman, extended the thanks of the staff to Dr. DuBois and assured him that they appreciated the lecture very much.

Newark Beth Israel Hospital Clinical Society.

The monthly meeting of the society was devoted to a discussion of cancer cases for the last three years. Dr. Max Danzis presided. The president called on Dr. Edward J. Ill of Newark to introduce the subject.

Dr. Ill said: I have written to all the hospitals of the State at the request of the American Cancer Society to have meetings of the staffs of the hospitals in which this subject is discussed. At one of the trustees' meetings, I made a report of what had been done here in New Jersey and have come to the conclusion that we didn't reach what we wanted to. The difficulty was that patients didn't recognize symptoms sufficient to impress it on the doctors. I say again the patients didn't recognize the symptoms early enough to impress the doctor. You thirty or forty men here connected with hospital, see cancer quite often, but there are some men who very rarely see a case of cancer, and probably for everyone of you here there are three or four outside physicians who do not see a case for two or three years. One of the men in this country who is an exceedingly busy man of wide laboratory experience and has everything in his office that any man may want for his office, brought his wife to me. She was sick eight or ten months with marked symptoms, of cancer of the rectum. He had never seen but four cases. It seems very queer. At all events the early symptoms of cancer should be impressed on every man. If these doctors themselves do not handle that kind of a case, they should

send it to someone who knows how. The Mayos report 78.8% cures of early cases of cancer. We'll take that with a grain of salt. I don't believe there is such a high recovery. They have lost track of some of them. Epithelioma of the face is almost absolutely curable in the early stages. They must have taken these. A man had the back of his ear entirely eaten up with cancer—epithelioma, received radium and was almost perfectly well after three years. We'll discuss the early symptoms of cancer or call it the want of symptoms. We would go a great ways to let it be understood what the early symptom of cancer is,—if everyone would understand that pain is a late symptom, and it is probably too late for any interference. If we could only understand that. They come to us and say, "She had no pain." Only today, I saw a woman who four years ago this winter was down at Florida, 7 years after cessation of menopause and she had cancer of the body of uterus. No one recognized it. A man at Rutherford, a busy man, didn't recognize it. She had a bloody watery discharge from the vagina. There is one symptom which is often not recognized. That is fever. We usually say cancer goes along without fever in a certain proportion of cases. In some cases there is marked fever. I saw a remarkable case with Dr. Pierson of Morristown. He said: "I have a young boy, a college man, who has come home and has pain in his left side with a fever of 103 and 104. Come and look at him." Way down deep in the pelvis I felt a mass which was painful to him. He was sick about one month. The fact that I felt this tumor and saw a few cases of cancer with fever made me suggest that the boy had a deep-seated carcinoma. Other men said it was inflammatory trouble. A noted orthopedist said he thought the boy had some disease of the hip joint. The boy got no better. Bull was called and made an incision and found a deep-seated sarcoma. The boy died four months from the beginning of his disease. He had had fever and pain. That is the usual result when fever and pain are connected. I saw a case with one of your men here the other day. It looked like a marked case of phthisis. The disease was sarcoma. Years ago, there was a woman in the ward of St. Barnabas' Hospital with a tumor of the liver, she had high fever and chills. It felt like a gall-bladder inflammation. She was a ward case and I transferred her to Dr. Young, who opened her and sent for me. She had carcinoma of the liver. I operated on the young woman. She had high temperature. You must bear in mind the fact of fever. When we had the cancer meeting in St. Barnabas, I had seen 230 cases of cancer and spoke of fever in connection with the cases. Of the cases that had fever, 52% were cancer of the liver and 16% cancer of the lung. Cancer of the liver and lung are usually secondary to some other difficulty. The question is always whether fever isn't secondary. When you have fever with carcinoma of the stomach or bowel, that is different, because there may be infection. If there is fever with cancer of the rectum the patient is going to die within a few days because the lower down the tract you get, the more serious is the infection. Cancer

of the stomach with fever is rare. When cancer is at the lower end, they die soon if you have an infection of ordinary character. I venture to say that most of you young gentlemen will see the day when cancer germ will be discovered. Years ago, John Clark ridiculed me for this statement, but the other day when I was to see him, he said, "I believe you are right, I believe that day will come."

Maybe your president will remember a woman at the Jewish Hospital, a woman whom I had seen at St. Barnabas' Hospital, one of Dr. Birmingham's patients. She had a large gland under her arm. He said it was carcinoma. I told him to cut one gland out and looked at it and there was no question at all as to the nature of it. Somebody asked me to see this woman again at the Beth Israel Hospital. She didn't have a gland either, but was covered from head to foot with eczema. They gave her a full dose of salvarsan and the glands disappeared, but she died from eczema. It was a remarkable case. At the last meeting of the society in Baltimore, Dr. Young reported about a dozen cases of sepsis that were promptly cured by injection of mercurochrome. (You see I must keep these new terms in mind.) I am going to make another prognosis. The day is coming when radium and surgery are going to be discarded and someone is going to invent something which, by injecting into the vein, will cure carcinoma.

Dr. Danzis said: Dr. Singer will read a report and in this report are embodied all the cases of cancer admitted to our hospital since 1921.

Dr. Max Singer read his statistical report of 108 cases of malignancy in the hospital for three years, as follows:

There were 108 cases of malignancy in the hospitals for the years 1921, 1922, and 1923, distributed as follows: Gastro-intestinal tract, 47; female generative organs, 24; female breast, 9; gall bladder and liver, 5; lymph nodes, 4; skin, 4; pancreas, 2; bones, 2; lungs, 1; G. O., 5; generalized (primary focus being indeterminable), 5. The malignant tumors were those sectioned (55). Carcinoma, 44; epithelioma, 2; hypernephroma, 1; sarcoma, 6; melanosisarcoma, 2. The diagnosis of the other cases were arrived at by gross specimens at operation and by associated symptoms and physical examination, and laboratory. The series embraced: males, 42; females, 66. Average age of males 50.3, average age of females 48.6. Grand average 49.4. Case carcinoma of caecum 22. The average time elapsed between appearance and symptoms and entrance to hospital was 6.9 months. Of the total 23 were classed as early cases. 8 of the series were operated at other hospitals for the same symptoms for which they came to the Newark Beth Israel Hospital. 4 were re-operated by our surgeons for palliative effect. 43 cases entered hospital with metastasis, evident physically or roentgenologically or at operation. Of the malignancies 22 were superficial and 86 deep. Of early cases 10 were operated with 2 mortalities (operative), 10 had radium, and 3 refused operation. 46 cases were operated with operative mortality of 20. 29 received radium, with 2 mortalities. 7 were both operated and had radium with 1

mortality. 26 were not operated, with 21 mortalities.

The conclusion one would obviously draw from this series are those generally accepted:

(1) Very few tissues are immune from malignancy. (2) That in people between ages of 45 and 50 with dysfunction one should be very careful to rule out malignancy. (3) Publicity as to the prevalence of malignancy and its devastating effects should be made known to the laity. 1.3 per cent. of our admissions were Ca. (4) Patients of this age with a chronic disease resisting treatment should be sent to hospitals earlier and every means of diagnosis be utilized. (5) That at present, surgery and radium (or x-ray) give best results as to longevity and possible cure. (6) That ulceration of an organ communicating with outer world, obstruction, cachexia, pain are later symptoms of malignancy and therefore almost sure death. (7) That any hard tumor on the skin which grows rapidly is suspicious, and which invades overlying and underlying structures.

Dr. Ashur Yaguda of the hospital was then called on to speak on the Pathology of Malignancy he said: Being of necessity limited to ten minutes, it seems best to avoid entering into a discussion on the many phases which might be gone into under the general pathology of malignant growths. I will therefore attempt to confine myself to a few remarks on topics which are of practical value in the early diagnosis of malignancy and try to point out what feature of neoplasia may be of aid to the surgeon or medical man in determining the malignancy or benignity of a tumor, the rapidity of growth and the prognosis.

First let us consider "what is a malignant growth?" From a purely clinical standpoint it would be impossible to draw any distinction, since nearly all tumors may occasionally prove fatal. The tendency is to restrict the term to tumors which show certain features which are especially harmful to the host. The more important of these features are: 1. Infiltration and invasion of the tissue in which it arises. 2. Rapidity of growth. 3. Local recurrence. 4. Formation of Metastasis. The diagnosis of malignancy is accomplished at once, and as a rule by microscopical structure. Under some circumstances, the microscopical structure may stand alone and override all other considerations. However, it is far more usual to find the interpretation of histological structure to be greatly influenced by clinical information regarding the location of the tumor, its attachments, the presence of a capsule and the age and condition of the patient. The history often furnishes valuable diagnostic aid. A tumor which has existed a long time and has grown slowly and steadily, is probably benign. If a tumor has grown slowly for a long period and suddenly takes a rapid growth, it has probably become malignant. **Rapid growth always creates a suspicion of malignancy.**

The relation of the tumor to the surrounding structure is of importance in the clinical diagnosis of malignancy. Benign tumors proliferate by expansive or central growth, pushing aside the tissues in which they grow. They have connective tissue capsules and are movable or the tissues can be moved over

them Malignant tumors grow by infiltrating the surrounding tissues and are as a result firmly attached to the surrounding parts. They have no capsules and often have no sharply defined boundaries. The number of tumors, pain, cachexia, and the age of the patient must also be taken into consideration in the clinical differentiation between benign and malignant tumors. Because there are a certain number of cases in which it is impossible to differentiate clinically, and, as I said before, the subdivision into benign and malignant is accomplished as a rule only by microscopic examination, it would seem that the removal and histological examination of all neoplasia as soon as they are seen, and not when the diagnosis is self-evident, because of metastasis, cachexia and other clinical signs of malignancy, would mark the beginning of real cancer control. This may at first blush appear to be a very radical and unwarranted procedure. But, when we consider that the incidence of death from cancer has shown a steady increase from year to year, so that no practically one in every seven deaths over thirty years of age is due to cancer, it may readily be seen that radical procedure is necessary if we are to check the mounting figures of death from cancer.

The surgeon should familiarize himself with the microscopic appearances of the tumors removed at operation. An inspection of the cut surface of the tumor gives valuable aid in diagnosis. A malignant white cut surface, dry and of rather firm consistency in characteristic of fibroma. The drier the cut surface of a tumor and the more distinctly it is encapsulated, the more likely it is benign. Inequalities in the character of the surface, alternating soft and hard spots, here and there are suggestive of malignancy. There are many gross characteristics which differentiate various forms of benign and malignant tumors, but for obvious reasons, we cannot discuss them at this time. This covers in a rather sketchy way, the clinical and anatomical diagnosis of malignancy. We now come to the microscopic study of tumors and the information to be obtained therefrom.

I would like to call your attention again, that most of the tumors found in the body are derived from pre-existing cells of normal type; tumors of connective tissue groups, arriving from connective tissue elements while those of the epithelial variety arise from epithelium and so on. Occasional exceptions are found in those neoplastic growths, complex type derived from congenitally displaced tissues (myxoma, etc.) Most of the primary tumors originate from structures normal to the site where they grow. In general, it may be said, that the tumor cells resemble more or less closely, the calls from which they originate. It is a well recognized fact that a neoplastic growth will tend to reproduce a structure from which it originates, and that the greater the variation in type, between a tumor and its originating tissues, the more malignant the tumor. Here we have a definite index as to the malignancy and rapidity of growth. Practically every surgeon who follows his post-operative results in cancer, has occasionally been surprised to find that in some of his extensive cases, patients lived

much longer post-operatively than others with easily removable small growths.

Aside from the rapidity of growth of the tumor itself, a very important factor having a significant bearing on the prognosis is the reaction of the tissues against infiltration of the tumor cells. One of the first reactions against the invading tumor, if the tissue shows a tendency to resist its progress, is lymphocytic infiltration. In a recent study of the factors which influence longevity in cancer, McCarthy found that in general when fibrosis was present in association with cancer, post-operative length of life was increased 30 per cent. When hyalinization was present in association with cancer, the increase was 40 per cent. When both fibrosis and hyalinization were present, post-operative lengths of life was increased over 56 per cent. (Study on breast and rectum cancer.) Of extreme importance are signs of increased nutrition and vitality of the cells. Taking into consideration that a parallel exists between the histological structure and the usual clinical course of a tumor, it may be readily seen that the relative malignancy of a tumor and a prognosis may be obtained from careful histological study. The surgeon should also be thoroughly familiar with the lymphatic drainage system of a body and with the blood supply, in order that he may the more readily detect secondary metastasis which should be looked for as part of the routine clinical examination of any tumor. It is needless at this time to go into the channels of metastasis of the various types of tumor.

The treatment of choice is of course surgery with a radical excision of the tumor and resection of the lymphatics draining the area. Exceptions of this exists, as for instance, the treatment of rodent ulcer. Radium and x-ray have been used both to replace operative interference and in conjunction with surgery. Dr. Greenfield will tell you more of this phase of the subject. Many fads have been introduced from time to time such as auto-serotherapy, injections of various tumor extracts, etc. In order to emphasize some of the important features mentioned, a short summary would not be amiss.

The early diagnosis of the malignancy of an existing tumor should be attempted. Insist on a histological examination of the tumor when you first see the case. Rapid growth should always make you suspicious of malignancy. Fixation of the tumor is a frequent sign of malignancy. Insist on the pathologist's presence at the operating table. The gross diagnosis of malignancy and a quick frozen section may prolong the patient's life.

A very good guide as to prognosis may be obtained from histological study of the tumor. Factors tending to increase the post operative span of life are: 1. The more perfect differentiation of tumor cells. 2. Lymphocytosis, a fibrosis and hyalinization, showing a marked local reaction against the spread of the growth. 3. Immediate and radical excision of the entire tumor together with a complete resection of the entire lymphatic drainage system of that part. (This is very important as it has shown that while there may be no enlargement of the lymph glands, the ducts may be packed by a continuous

growth of tumor cells, Handley's lymphatic premeation.) 4. Post-operative radium or x-ray treatment.

Dr. C. J. Halperin said: We find that epithelioma of the skin is fairly common after forty years of age, usually on exposed parts of the body such as the face, back of hands, etc. Men who are out in the air a good deal develop senile warts on the face, which is a pre-cancerous condition. Several types of skin affections are considered pre-cancerous. The ordinary Nevi are subject to malignant degeneration in later life and flat warts in old people. Then, of course, chronic conditions, such as Lupis Vulgaris and even syphilitic ulcers may develop into Epithelioma. Men who handle tar and other chemicals are likely to develop malignant degenerations of the part that comes in contact with the chemical. A malignant lesion of the skin usually starts as an innocent looking nodule or tubercle and the patient thinks it is an ordinary wart and may go to a druggist, who will apply phenol or nitric acid and the result is that the condition becomes irritated and spreads. An ulcer is formed. The border is hard, waxy and of a pearly color. Use a curet on it, and it breaks down readily. The tissue is very friable. There are two kinds of epithelioma on skin, one is the ordinary nodent ulcer type, the other the prickle cell type. The first type is more favorable to treatment, simple curetting or acid will cure this type. It gives a very favorable prognosis. As Dr. Ill mentioned, most of these cases are curable. Radium, of course, in the basal cell type is ideal. The prickle cell type must be determined by the microscope. It is the more malignant type and gives better results by surgical methods. Epithelioma of the lower lip is better excised together with the glands of the neck and radium applied. There is one condition that is perhaps rare, that is, Paget's disease,—disease of the nipple or of the breast and begins usually in women after forty. The ordinary appearance of eczema or dermatitis usually on one breast doesn't give marked symptoms for a long time. There is a scaly condition, and a slight serious discharge, usually treated for several years but doesn't get better. The inevitable results is malignant degeneration. Cancer is the result. The microscopic condition discloses certain cells even at an early time. There is no reason for making mistakes in a condition of that kind in women of forty developing dermatitis. It is better to have a section made to make a positive diagnosis.

Dr. M. J. Fine was then introduced, and after reading his case of carcinoma of the apex of the lung, which had been previously treated for pulmonary tuberculosis, rendered the following discussion. The prognosis of carcinoma of the lung is hopeless but it may last for years. Pneumothorax is not an uncommon occurrence in the course of the disease. Dr. Hammon says that carcinoma of the lung is an uncommon disease. Dr. Ewing claims that 1 per cent. of cancer occurs in the lungs. Baron claims that disease is on the increase and that the possible factor may be chronic inflammation, such as tuberculosis and influenza. He also states that the carcinoma originates from the bronchial epithe-

lium, from the bronchial mucous glands, and from the alveolar epithelium. Wilensky did a great many operations in cancer of the lung with 100 per cent. mortality. Hines reported 2 cases of cancer of the lung, treated early, with very beneficial results.

Dr. Danzis: Dr. Julius Levy will speak on occurrence of malignancy in children. Dr. Levy: Cancer is very rare in children. There have been about 103 cases reported about three-quarters of which occurred between the ages of 8 and 15. Kurley, in his vast experience has never seen a case. Sarcoma is not uncommon. In our small service at the hospital, there were two cases of sarcoma of the kidney. One was operated, the other was diagnosed and the patient left the hospital. At the time of the operation a tumor filled the entire abdomen. The tumor was removed and the child died after. These tumors of the kidney give remarkable few symptoms. General cachexia is not marked until late. The only guide is a careful examination of the whole child whenever the mother notices that the child complains of any gastro-intestinal symptoms. It is of general importance to have a complete and thorough examination for what may appear a trivial complaint. Literature refers to a number of congenital cases of malignancy in infants. The most common is malignancy of the liver and suprarenal gland. The most common congenital type is that of the liver. In the reports of the congenital tumors, it is stated that they are usually discovered when the infant is a few weeks' or months' old and it is rapidly fatal. Van Reuss says that the prognosis need not be hopeless. If the diagnosis is made early, there is a possible chance of treatment. In the reports of congenital cases, several people mentioned fever (Dr. Ill brought out this point). It might be well to think of fever in the child, in connection with malignancy.

Dr. Danzis said: I have collected a report of 15 cases of cancer, which I followed up and the story is a very sad one. Some of these cases bring out this point. I will take up first 9 cases of cancer of the breast that were operated in the last 7 years, that is, those that I could trace. Many others I have lost track of, as it is sometimes hard to trace them. These nine cases have the following results: 4 are alive. Two of these 4 are perfectly well today. 2 were operated the last 2 or 3 years, 1 has metastasis now, the other I am not certain about. 5 of these cases are dead. 2 died of metastasis in the spine, one of these 2 metastasis of the cervical portion, one of the lumbar portion. 2 died of metastasis of the lungs, one died one year after and one two years after the operation. Three of these cases that died, received x-ray treatment after the operation, three or four times. 2 of those gave a history of one year to eighteen months. One case who was operated about 6 months ago, complained of pain and I thought I could feel a mass in the abdomen. Of these 9 cases, 5 came to operation very late. One carried around a lump in her breast a year and a half. She consulted several doctors and each one thought it was something else. When she came to us, she was pretty far advanced. The lesson I have learned from these cases is that in the future I would x-ray every patient.

to be prepared to know what to tell the family. We were in the habit of cleaning the axilla thoroughly and taking everything out. We can't hold ourselves responsible for overlooking something that should have been taken care of. We have here 3 cases of cancer of the bowel. The time is too short to read the histories but we have the reports here. In a great many cases cancer of the rectum is curable, especially at the rectosigmoid junction. Recently, I read a report of a man in California who reported 10 cases of carcinoma of the recto sigmoid junction, at Chicago Surgical Clinic. Four of these cases were protoscoped after operation was made. Six of the cases remained perfectly well and some of them are alive after seven years. We didn't have that experience. We have two cases I would like to read you the history of. One of these was an old man about 70 who suffered from a mass in the abdomen about one year and a half. His condition was too far advanced for anyone to relieve him. Another case we operated which was an early case, the patient being sick about nine months. She died a week following the operation. I would like to read you the history of carcinoma of the ano-rectal junction in 1918. In this case we brought down the rectum to the anal region, thinking that we might be able to get a well functioning muscle, because there was no trouble in bringing it down, but unfortunately, the wound was infected. She made a good operative recovery. Many months later she began to complain of prolapse of the rectum, for which we did a second operation, hoping to bring the rectum up and stitch it to the sacral region. We succeeded to cure her of the prolapse. She has some control of the sphincter muscle. It is five years today and she is alive. It is the only case in my experience that is cured. On the other hand I wish to speak of another case who consulted me and complained of pain in the back. Someone made a diagnosis of retroverted uterus. She said she had lost some weight and had pain at night. I told her to be x-rayed. The x-ray proved a beginning of malignancy in the recto sigmoid junction. I advised an operation. She was operated in New York, and had a good operative recovery. She died six months later. This was an early case and a good operation. In breast cases, I want to say again, I think we are really neglected often in failing to diagnose them. Every case I operated was a late case. There is no excuse for a woman going around a year and a half carrying a tumor. One woman had a lump in the axilla. We have two cases of cancer of the penis. One man was operated September 28th, 1919. He had epithelioma. He made a good operative recovery. The meatus would occasionally contract and he would have some difficulty urinating. I would dilate it and fixed the urethra, but it contracted again and I continued to make him comfortable by dilating it. A cystotomy was made on him. He was a man of 67. He is perfectly well. Dr. Halperin made the diagnosis, I think. It was an early case. These cases simply teach one a lesson that accessible cancers ought to be operated real early. There is no excuse for cancer of any part of the body to go around for months

and years without being impressed that an operation is urgent. Dr. Robbins has a case to report of sarcoma of the ovary. He read the history and course of the case.

Dr. Danzis called on Dr. Ill to close the discussion.

Dr. Ill: I have been very much instructed by what you have said, but the pathologist doesn't know it all. In a great many cases, you send specimen to four or five different pathologists and get four or five different diagnoses. In 1885 I removed my first two desmoid tumors of the abdominal wall and took both to Dr. Delafield and Pruden and both announced it as sarcoma. Both patients are living to this day. Even now, when I make my rounds in different parts of the country I take the specimens with me and some pathologists say it is sarcoma, and some say it is inflammatory. The desmoid tumors are always circumscribed and are all attached to the transversalis fascia. Dr. Yaguda said that the best treatment was surgery, but gradually we are leaving it. I want to be definite about that. When I got my last German Medical Journal, a man from Freiburg who discovered twilight sleep reported some remarkable results from radium. I came across a letter today which I received four or five years ago about radium used on carcinoma of the cervix and uterus. 40 per cent of the cases remained well over five years. No deaths occurred from application. Nobody had that result from operation. The best results a man got was Peterson, who had about 30 per cent. of recovery after five years and lost about 40 per cent. of his patients by operation, a tremendous death rate. John Clark reports 21 cases of carcinoma of the cervix lived over four years, treatment being radium. I have had neither a death nor a recurrence in 25 years in carcinoma of the body of uterus by operation. Three times during the last four years a large quantity of radium was put into a case of carcinoma of the cervix. In hundreds of sections that Dr. Gray made you couldn't find a single trace of carcinoma of cervix. In the diagnosis of skin cancer, Dr. Halperin made a very important remark, the use of the curet. The tissue of carcinoma is so friable that the curet will go into it like cheese. You have carcinoma when it goes into it like cheese, and you don't need the pathologist. I am interested in what Dr. Danzis told us about cancer of the breast. I went to the Memorial Hospital a few weeks ago to hear a discussion. The results of operation on carcinoma of the breast have been terrible. The gentleman from Bellevue said about 10 per cent. was the percentage of recovery. He had to take it back. I wouldn't dare to say about 10 per cent. I did about 160 cases. You have got to remove the original tumor with the glands of the axilla in one piece and mustn't cut between the glands and axilla or the patient will die. You must cut one piece and never see the carcinoma gland. Supra clavicular carcinoma I never operated at all. I never would. In the older days I split the clavicular and took out the glands above. I never saw one get well. We must be very strict. Another thing to do which is very important is to have x-ray pictures taken of the spine within the last few days before operating.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

CHAS. D. BENNETT, M. D., Chm., 177 Clinton Avenue, Newark.

JOHN B. MORRISON, 97 Halsey St., Newark.

EDWARD J. ILL, M. D., 1002 Broad St., Newark.

DAVID C. ENGLISH, M. D., Editor, 65 Paterson Street, New Brunswick.

EDITOR:

DAVID C. ENGLISH, M.D.,
P. O. Box 83, New Brunswick

ASSOCIATE EDITORS:

CHRISTOPHER C. BELING, M.D., Newark

HENRY B. COSTILL, M.D., Trenton

JAMES HUNTER, JR., M.D., Westville

HARRISON S. MARTLAND, M.D., Newark

FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

We take great pleasure in adding Dr. Fred J. Quigley to our list of associate editors, with the approval of our Publication Committee. As one of the active workers of the Welfare Committee he will especially give our Journal editorials and facts concerning our Profession's activities in promoting the Public's Welfare.

We had hoped to send our annual Official List with this month's Journal, but the amount of time taken to make it accurate has made it impossible. Much credit is due to our Secretary, Dr. Morrison, for the immense amount of time and care he has given to secure greater accuracy. It will be sent with the April Journal.

We have received from Dr. Hunter an account of the address delivered by Dr. David Reisman recently on retiring from the presidency of the Philadelphia County Society. We will refer to what he had to

say on "State Legislature" and "Medical Cults" in our next month's issue.

The Welfare Committee has had several meetings the past month and has done good work in perfecting and endeavoring to secure wise health legislation. They secured a hearing March 3rd before the Senate Committee on Bill 159, and Drs. Eagleton, Quigley and Pinneo made excellent addresses while the opposition talks were long, critical of the profession, protective of the cult rather than of the public, and we believe helped rather than hurt the Bill. It is believed that the Bill will pass. Other bills are yet in some doubt. The Editor returns sincere thanks for the committee's and the State Society officers congratulations sent on his 82d birthday anniversary March 2d.

The Editor enjoyed meeting his many friends and associates at the annual dinner of the Hudson County Medical Society on February 9th. The dinner was one of the best he ever attended, the place at the Elks' Club an ideal one and the speakers—Hon. G. W. Whiteside and Dr. Louis Harris, both of New York City, had intensely interesting and helpful messages. We know the officers of our State Society and Commissioner McBride, who were invited guests, will agree with our judgment of the occasion. Drs. Luippold, Perlberg, Londrigan and Woodruff, the dinner committee, deserve much credit.

DIRECTOR OF SCHOOL HEALTH.

We regret having inserted in our February Journal the editorial "Important!" concerning the Legislative Bill for the appointment of a Director of School Health. We understood at the time that it was approved by the Welfare Committee of our State Society. We subsequently were informed that it was not one of the bills our committee favored, but that they were opposed to in its present form. The committee at a recent meeting requested, by unanimous vote, its withdrawal and decided to oppose it if not withdrawn. One of the chief objections to it was: that the director was to be appointed by non-medical men, was to be a practitioner of five years' standing, was to have full power without proper supervision of his work for five years at a large salary.

The Welfare Committee while in favor of the general principles of the bill,

believed there should be much more careful consideration of its provisions. The bill was withdrawn from legislative consideration and action.

PROFESSION AND THE PRESS.

We call special attention to the editorials taken from the secular press which we insert on pages 109 to 111. It is exceedingly gratifying to note in these days such articles when so many newspaper publishers and editors seem to be in the mad rush for money-making that they admit all kinds of advertisements of quack doctors and quack medicines so utterly regardless of their great duty to protect the public, especially in the saving of human life and the protection of the health, that they refrain in their editorial columns from warning the public against trifling with these sacred things.

We note especially the large number of practically worthless medical advertisements with men's and women's pictures and accompanying testimonials, how the medicine saved their lives or restored their strength when all other remedies had failed. Many such persons to get their pictures in the paper would give highly laudatory testimonials, when the faces of many such endorsers indicate no high grade of intellectuality or desire to help others.

Such newspapers have sometimes criticized doctors for their high prices, but have nothing to say of the legal profession whose charges are often five to one, sometimes ten to one of the doctor's, while they make little of the doctors' great sacrifices in preventive medicine and in other public and private charity.

LAY EDUCATION.

Equipped with a background of years of valuable experience, our legislative chairman will conduct his campaign for enactments favorable to the protection of the health interests of the State.

The closer relationships which he has established with county chairmen, and a livelier sense of interest in all members of the State Society which he has developed, would seem to promise him greater assistance than he has hitherto enjoyed, but he has all the handicaps that are enjoyed by any honest lobbyist who has nothing to trade.

He is asking for nothing but the salvage of the children of the State, the salvage of the people who, by their citizenship, make

up the State, the salvage of the crippled, of the insane, and of those incompetent to care for themselves.

He has behind him only a small group of really educated, and really altruistic people. He has against him every faddist, every silly cultist, every job hunter, and every crooked place holder who has defied indirect methods of getting unearned, excessive reward from the public purse.

The longer one studies the history of legislation, the attitude and arguments of legislators, the more important seems to be the education of our citizens, so that whatever professional, or business, lines they follow, they shall have impressed upon them certain fundamentals which they will respect and which will influence their mental attitude toward matters of public health, disease prevention, and the care of those who are physically and mentally in need of scientific medical attention.

The special and scientific journals cover such limited fields that only a most limited influence can be attained we must look for help to agencies of such broader distribution and influence as only the lay press possesses.

While we must foster, watch, and fight legislation, we would do well to assiduously cultivate public opinion and constantly present to all the people educational matter along public health lines.

Such a movement is being attempted by the Illinois State Society, a large number of the members of the Society having subscribed for its support.

If the members of county societies will make persistent effort they may succeed in enlisting the help of newspapers in every part of the State even to the extent of sacrificing revenue from quack advertisements.—N. Y. State Journal.

"QUACKS" AND "REAL DOCTORS."

(From the New York Times.)

Dr. Paul B. Brooks, State Deputy Commissioner, contrasts "Quacks" with "Real Doctors." Cults prey on public credulity. Pretensions and exaggerations mercenary. If cult claims were effective, such instructions would be given in medical schools, commissioner says.

In a radio talk broadcast recently from station WGY, Schenectady, Dr. Paul B. Brooks, State Deputy of Health, explained the difference between "reputable" physicians and "quacks." Tracing the history of medicine from the time of Hippocrates to the present, he stated that medicine is

founded upon a "sound, scientific basis," and that it is now entering upon an era in which prevention of disease is to assume the leading role. "Just as we now employ lawyers to keep us out of trouble," said Dr. Brooks, "the doctor of the future will be expected to keep his clients well."

He stated also in effect, that a "reputable" physician undergoes an intensive training of long duration that requires a high degree of intelligence, a long period of study, and an expenditure of several thousand dollars before he is competent to undertake the responsibility of safeguarding the public and being entrusted with human lives. Thirty or forty years ago, practically every one had his family doctor. In times of sickness his visits brought encouragement and cheer; he was a general counsellor and advisor. His life was one of service to others. When he died, he left behind him a little besides loving memories.

Ian Maclaren placed upon the tombstone of his "Doctor of the Old School" the following inscription: "Greater love hath no man than this; that a man lay down his life for his friends." When the author was asked if he had ever known a doctor so self-sacrificing and so utterly christian as the Dr. MacLure of his story, he said: "Not one man, but many." Today, for many reasons, the relations between physicians and patients is more nearly a business relation, and is less intimate than it was years ago. Nevertheless, the doctor is still the advisor and confident to whom many families turn in their most serious troubles.

The proprietor of one of the greatest shows once said that the American people like to be humbugged. A great many others have taken advantage of this trait which, incidentally, is not common to Americans alone, by starting all sorts of cults and "systems", the main purpose of which is to convert human ills into cash. Just as a hungry pike will jump for a minnow, so it appears will human nature respond to any attractive bait in the form of an offer to cure sickness by some new "system."

Doctors are accused of being narrow and selfish because of their efforts to put imposters out of business. It is true that altruism is not the only reason for their efforts to stop people from sacrificing themselves on the altars of false gods of medical quackery.

Academy of Medicine, Northern, N. J.—The stated meeting was held February 20th. Dr. J. Shelton Horsley, Richmond, Va., read a

paper on "Surgery of Intestines, with Special Reference to Physiological Principles."

The section on Eye, Ear, Nose and Throat met February 11th. After report of cases, Dr. S. H. Baldwin read a paper on "Chronic Aural Suppuration."

The section on Medicine and Pediatrics met February 13th. Dr. Max Einhorn of the Post-Graduate School and Hospital read a paper on "Direct Examination of Bile in the Diagnosis of Gall Bladder Affections," with lantern slides. It was discussed by Drs. Carman and Asher.

The section on Obstetrics and Surgery met February 26th. Dr. H. C. Herold presented case of Toxemia of Pregnancy. Dr. F. D. Bunting case of Extra-Uterine Pregnancy and Dr. N. Price, case of Juvenile Pregnancy and Dr. J. F. Condon, case of Post-Natal Follow-up. A paper was read by Dr. W. S. Bainbridge, New York, on "Treatment of Advanced Uterine cancer."

March Meeting.

The March stated meeting will be held March 19th at 8.45 P. M. An address will be delivered by Dr. Wells P. Eagleton on the work of the State Society Welfare Committee. The anniversary discourse will be by Dr. H. R. Ruzby of New York on "The Caapi Drinkers of Columbia."

The Section of Eye, Ear, Nose and Throat will meet March 10th at 8.45 P. M. An address will be delivered by Dr. W. Pyle on "Cases of Sudden Blindness."

The Section on Medicine and Pediatrics will meet March 11th at 8.45 P. M. A Symposium on Pneumonia will take place with addresses by Drs. F. A. Alling, R. J. Mullin, H. M. Ewing, W. Petry, A. Gaguda, G. Blackburne and H. H. Kissler.

The Section on Surgery, Obstetrics and Gynecology will meet March 25th at 9 P. M. Paper on "Acute Perforating Gastric Ulcers" will be read by Dr. M. Danzis and C. M. Robbins, with discussions.

PRESIDENT EAGLETON'S LETTER TO SENATORS EDGE AND EDWARDS.

February 8, 1924.

Dear Senator:

As you know, the medical profession of New Jersey for the last three years have been organized for the purpose of insisting on the policy that medical men alone are competent to handle health problems. Behind this policy stands every medical man in New Jersey. It has come to my attention as President of the Medical Society of the State of New Jersey that the District Manager of District No. 2, United States Veterans' Bureau, which comprises New York, Connecticut and New Jersey, has never had a medical man at its head.

The scandals of the Veterans' Bureau that have brought such disgrace on the nation and so discouraged the disabled soldier, are largely due to the lack of understanding of proper medical policies and a failure to recognize that doctors are alone competent to dictate such policies. I am a member of the Advisory Board of this district, and as such, and as President of the Medical Society of New Jersey, I am requesting that you immediately see

General Hines and request of him that in the appointment of the new district manager a physician alone should be appointed and only one whose outstanding professional qualifications would bring the confidence of the medical profession and of the disabled soldier.

I am informed that many politicians are now looking for this job, and I beseech your early co-operation to prevent the miscarrying of proper administration to the disabled soldier. Such men as Dr. Haven Emerson, Dr. Joseph Blake, Dr. John A. Hartwell, Dr. Thomas Salmon of New York, or men of this type should be in charge of the work.

Very truly yours,

WELLS P. EAGLETON,

President, Medical Society of New Jersey.

They Claim Too Much.

(N. Y. Tribune Editorial.)

The chiropractors are renewing at Albany their effort to obtain a legal standing. If the cult is to be tolerated in New York regulation of its practice is desirable, but the terms no which chiropractic demands recognition would raise it to a plane equivalent to that of medicine. It would be folly for the State to grant any such indulgence.

The spine manipulators are innocent of medical knowledge. They deny that they practice medicine, yet they ask for the right to sign death certificates and to pass under the title of "doctor." They would assume functions of the physician without submitting to the usual examination. The answer to these pretensions is simple. They can secure the privileges of doctors by passing the regular tests of the Medical Examining Board, as osteopaths are required to do. Having qualified as physicians they can confine their treatment to chiropractic if they choose. Why are they unwilling to come in by the front door? Because they will not take the trouble to provide themselves with a key. They disdain a medical education, say they have no use for it in their business, therefore it is cruel to compel them to spend money learning superfluous theories. Chiropractic, they say, is a different "science" from medicine and needs only a high school education followed by a special course of training. So they would become "doctors" by license of an examining board of their own.

The ambition of the chiropractors is to have the control of their school entirely in their own hands. They insist on a board of chiropractic examiners appointed by the State Education Department. These examiners would approve candidates for licenses to be issued by the State Board of Regents. It would be a dangerous concession. Physicians should have representatives on the board. An impressive jargon conceals the fact that chiropractic is essentially a form of massage. If its votaries can be licensed as expert masseurs or spine adjusters and held within the limits of their specialty that will be a sensible measure. To set up the cult as a branch of healing co-ordinate with medicine would be a mischievous proceeding. The Legislature will do well to hold to that view as it has done heretofore.

Assault on Jersey Standards of Medicine.

What is there about the branch of healing called chiropractic which allies it with the profession of war? The question is neither flippant nor idle. Last year's Legislature provided that any World War Veteran, trained in chiropractic under federal rehabilitation service supervision, who could provide evidence satisfactory to the State Medical Board of such training, should be entitled to a license to practice. Interpreting this mean that the Medical Board could not require them to pass an examination for a license, some veterans took the question before the courts in November, and there it remains, waiting decision.

The committee on public health in the upper house of the present Legislature has before it a bill by Senator Mackay which would extend the same privilege to Spanish-American War Veterans, provided applicants had put in five years as members of the National Guard in this State. Must the few remaining Civil War Veterans, if any of them should aspire to be chiropractors, wait until 1925 to get on the list? Unhappily, we have no remaining known Veterans of the Mexican War or the Revolution in New Jersey. But would it not be entirely in keeping with this sort of legislation to provide that sons of veterans of our earlier wars, or even their grandsons, could become chiropractors through the qualification of military ancestry?

This State gives full opportunity for new medical cults to show what there is in them for human benefit. But it requires that their exponents shall demonstrate by examination in anatomy, physiology, diagnosis, symptomatology and other fundamental that they are grounded in knowledge of the organism they aspire to heal. Without that examination there is no safe basis for any healing license. On the contrary, lacking this demonstration of fundamental knowledge, any would-be healer becomes a potential menace to the people of the State. Connecticut's experience with the mixing of special privilege and medical certification has led New York and Massachusetts to check up their healers. A recent investigation revealed that that State, which ranks so high in many fields, is "among the half-dozen lowest" in standards of admission to the practice of medicine. New York has domain, and has started in to check up on discovered that there are no less than forty medical cults which are followed within her what they are and do.

We are not keeping pace in New Jersey, with the standards we have tried to build up. If for any reason whatever we permit any man or woman to take the life of another in hand, as a pretended practitioner of healing, without having ascertained by adequate examination, conscientiously enforced, that the individual is fitted for that high calling. It is not a question of chiropractic nor one concerned exclusively with the effort to make easy the path of the man who has served his country. It is a question of human lives and human usefulness. The doctor of healing who deserves his calling has an office second only to that of a priest of God. Such legislation as the Mackay bill represents would take that office back to the level it occupied when the

barber was the doctor, the leech his materia medica, the cemetery the best record of his practice.

Senator Mackay and others who stand for the sort of thing that is represented by Senate 247 should read that old French romance, "Gil Blas." It pictures the sort of mediciners they would, consciously or unconsciously, foist upon the people of New Jersey. And to do that ought to be a crime.—Newark Evening News, February 25th.

Making Healers by Wholesale Should Stop in New Jersey.

There is neither necessity nor justification for the passage of House 513, which seeks to legalize the practice of a cult of healing called naturopathy.

The limited license law of this state enables any person qualified to be a healer of human ills to obtain a license to practice if he has the fundamental training required to make him a safe practitioner. The name he may wish to give his practice is of secondary importance. The test of his fitness is what he knows.

The main purpose of this bill, from its own internal evidence, is automatically to license, without examination, persons who are now without legal recognition practicing the healing art under the designation of naturopath. It is a reproach to the State Medical Board, an indictment of its efficiency, that this practice is not stopped.

To be sure, we have done this very thing in the past—legalized a new cult, admitted its New Jersey practitioners without investigating their individual qualifications as healers, and started anew with a requirement that thereafter its novitiates submit to examination.

But in the light of the past year's revelations as to the uncertainty of medical and healing education outside the known qualified colleges, can we go forward on such haphazard lines, taking for granted what we can not know without examining the individual?

Legislators should keep one thing clearly in mind—the protection needed against unsound healers is needed by the masses. The man of education and means does not walk down the street looking for a sign with "Doctor" on it. He calls to his home or office a man whom he knows to be qualified. The risks are assumed by those less equipped with ability to protect themselves against fraud, in a field where fraud may mean death or permanent disability for lack of sound diagnosis and skillful treatment.

There is another danger in this bill. Following precedent which was sound when established, but can not safely be carried to extremes, it provides that a naturopathist shall be added to the Medical Board.

If healing cults are sufficiently multiplied in number, and his is done as each is recognized, the time will come when representatives of new cults, which have yet to prove their standing and their claims, will outnumber the qualified on that board. Then the only bulwark the people have against exploitation by quackery will be thrown down.

The Legislature is not commissioned to play politics with the lives of the people of New Jersey.—Newark Evening News.

Hospitals; Sanatorium.

Jersey City Hospital.—The report for the month of January showed that there were 849 patients admitted during the month and that with 345 patients remaining from the previous month, 1194 cases were treated. 754 were discharged during the month—312 cured, 320 improved, 4 unimproved, 43 transferred to other institutions and 75 died. 440 patients remained at the end of the month. In the dispensary 678 new cases were treated, and 1897 revisits. In the emergency room there were 813 day treatments and 137 night treatments. There were 737 ambulance calls made. There were 173 major operations, 199 minor operations and 73 T & A operations.

Salem County Memorial Hospital.—Four and one-half years' services of the Salem County Memorial Hospital ended in February, when a get-together dinner was given by the Board of Managers to the medical, surgical and dental staffs of the hospital. The dinner was prepared by the matron, served in the sun-parlor by the superintendent and her corps of nurses. The main feature of the evening was the statement that the hospital was free from debt. The mortgage was paid off and a gift of a \$3,000 check from the Dr. Ellen B. Smith Memorial Fund for the poor and needy. The round table discussion was on a new laboratory training school and larger laundry. Last year was a busy year, the hospital painted throughout, a new heater installed and concrete floor in basement. A new nurses' home was opened with a reception to the staff and public in November. The maternity department moved to the old nurses' quarters on the third floor, increasing the bed capacity of the hospital. 2,700 patients have been admitted; 806 accident cases treated and over 600 patients treated in the Dental, Tuberculosis and Venereal Clinics. \$7,957.70 were given to the World War Veterans and dependent members of their families. Therefore the unpaid services to the community has amounted to \$14,711.20 in the past four and half years.

Union County Isolation Hospital.—The County Board of Freeholders recently decided to build a county isolation hospital and appointed a committee to select a site.

Hospital for Eye Diseases.—A sixty-bed trachoma hospital equipped with special fittings to enable patients to feel their way by foot and having walls, lights and windows of a color not injurious to the eyes, will be constructed by the Veterans' Bureau at Pikeville, Ky. Plans for the hospital—the first of its kind in the United States—are nearing completion. They include a research laboratory for specialists in trachoma and other eye diseases.

No More County Hospitals. They Overburden the Counties.

(From the Newark Evening News.)

State Commissioner Lewis—the man who is in charge of the State institutions for defectives and dependents—has written a letter to

Governor Silzer. And that letter seems fairly to close the case as to what Essex ought to do by way of adding to Overbrook. The \$600,000 reception and treating building, needed to modernize Overbrook, ought to be built. The \$2,000,000 expansion plan ought to be dropped.

Looking at it from a State standpoint the reception building would fit in with a State policy, while the expansion program might prove embarrassing and eventually throw an undesired burden on the State or leave a wasteful one on the county. Commissioner Lewis points out that practically every other State in the union has had this question of county and State institutions to deal with and finally for the sake of the economy and efficiency involved has come around to a policy of State care. And that the least cost and best care can finally be obtained by this method is confirmed by a national commission appointed to study that subject. In other words, New Jersey is out of date with its mixture of State and county institutions.

From the particular standpoint of Essex there is every reason now to stop short on expansion pending the definition of a State policy. As it is, the cost of care of defectives and dependents tips against Essex. The more this and other counties that have their own institutions add to them, the more disproportionate their share becomes. The State contributes \$3.25 a week for each indigent patient in a county hospital and the counties pay the same amount for their indigent patients in State institutions. This is less than half the real cost. Of course, what Essex pays is money raised by taxation and which is paid by its citizens. But what the State pays from its revenues is also in good part money raised in Essex. So that the figures does not offset each other and the county continues to carry a disproportionate share of the burden, which becomes worse because the Essex hospitals cost more per patient, partly because there is more nursing care and partly because they are less overcrowded. And then, when it comes to considering new additions, Essex not only bears the entire construction cost of its own elaborate institutions, but will be taxed twenty-seven per cent. of the construction cost of State institutions.

It is a situation that patching is as likely to make worse as better. Senator Harrison had a bill that would make the indigent fee \$5, instead of \$3.25, thus tending to equalize costs, but it was reported as making the payments one-half of actual cost of maintenance of patients in county institutions. But there is likely to be constant dispute over the county care of State patients in all the different classes of institutions that the various counties maintain. One amendment proposed to the half-mill tax bill for the modernizing of State institutions and reported favorably by the House taxation committee provides for two State institutions in North Jersey for classes of patients requiring permanent care which, perhaps, fits in better with the State policy.

There is only one thing to work toward that will at the same time give the patients from any county the care that they ought to have, tend the most to their rehabilitation and ap-

portion the cost fairly. That is the State policy. We can not get there all at once, but we can begin by making the county institutions preliminary and for the care of particular types—perhaps mild able-bodied and mild senile cases—making the others subject to State care. The way to start that policy is to stop adding to the county institutions except enough to perfect them for this purpose and begin adding to the State institutions. Unless we do, Essex and such counties are likely to both penalize themselves and embarrass the State by taking on a disproportionate burden of institutions not fitted for their eventual purpose.

Deaths.

ALLEN-DE LUGA.—At Collingswood, N. J., February 23, 1924, Dr. Lida Taylor Allen-De Luca, from paralysis, aged 50 years. The doctor graduated from the Women Medical College, Baltimore, in 1906, and practiced medicine in Collingswood for the past fifteen years.

CRAVEN.—In Jersey City, February 25th, 1924. Dr. Joseph J. Craven, health officer of Jersey City for 13 years. A graduate of the College of Physicians and Surgeons, N. Y. City in 1888.

HOLLINGSHEAD.—In Pemberton, N. J., February 23, 1924, Dr. Enoch Hollingshead of that city, aged 81 years.

Dr. Hollingshead was born near Medford, N. J. He graduated from the University of Pennsylvania in 1867; began practice in New Egypt, N. J.; after four years moved to Pemberton, where he continued to practice till his death. He was treasurer of the Burlington County Society for thirty-four years; was president of the Medical Society of New Jersey in 1913 and after that a trustee of the same. He was also a member of the Philadelphia Medical Society and the Society of Friends.

The doctor took an active interest also in politics; he was a member of the original County Board of Elections named by Governor Leon Abbott, and served several years without pay even for legitimate expenses. His funeral was very largely attended and eloquent tributes were paid to his life and services. His honorary pallbearers were Provost Penniman and former Provost Smith of the University of Pennsylvania; Drs. Marcy, English, Ill, Tracy Marvel, Barrington, Meccray, Stokes, Herbert, Bickler of New Jersey and Dr. Kennedy of Philadelphia.

PRICKETT.—At Mount Holly, N. J., February 7, 1924, Dr. Elmer D. Prickett, aged 61 years.

READING.—At Woodbury, N. J., February 23, 1924, Dr. George Evans Reading, age 60.

Dr. Reading was born at Frenchtown, N. J., October 15th, 1863. Graduated from Jefferson Medical College in 1885. Located in Woodbury, N. J., the same year, and has practiced there ever since. He was stricken with pneumonia on the 19th, while attending to his practice, the disease resulting in his death four days later. He married Clementina Bates, December 22nd, 1887, who with two daughters

and seven grandchildren survive him. For thirty-five years he was the secretary-treasurer of the Gloucester County Medical Society, and was largely responsible for the reorganization of this society in 1890, when it had become all but moribund. He was also a member of the A. M. A., the Medical Society of New Jersey, the Medical Club of Philadelphia, Sons of the Revolution, Odd Fellows, Red Men, Knights of Pythias, A. O. U. W., Moose, State Firemen's Association, State Board of Medical Examiners, President of Good Will Fire Company and the Firemen's Relief Association.

In life, his cheerful confident spirit, faith in his mission and the tireless energy and optimism shown in his work, brought an early recognition of his professional ability. Stricken at the zenith of his powers, while busily engaged in the duties of an active practice, his death came as a shock to the entire community. His was the positive, active type of life, exemplifying the lofty idealism of those who have faith plus in their life motive.

"Carry on! Carry on!

Fight the good fight and true;

Believe in your mission, greet life with a cheer,
There's big work to do, and that's why you
are here.

Let the world be the better for you;

And at last when you die, let this be your cry:
Carry on, my soul! Carry on!"

Further notices concerning Drs. Hollingshead, Prickett and Reading will be given next month.

DAVIS.—In Somerset Hospital, Somerville, on February 7th, Mrs. Carrie Davis, wife of Dr. Henry U. Davis of North Branch.

Public Health Items.

Annual Audit of Health Asset.

Need of a yearly audit of an individual's health asset through a physical examination on the anniversary of the date of birth is to be stressed by the New Jersey Tuberculosis League in a three-month campaign, in co-operation with the National Health Council. The league added a special secretary to its staff for the campaign and assistance will be given by the welfare committee of the New Jersey State Medical Society.

In the campaign it is hoped that at least 10,000,000 persons in the United States will seek medical examination at the hands of their own physicians. The physicians of the State will be requested by Dr. Wells P. Eagleton, chairmen of the welfare committee of the New Jersey Medical Society, to make their examinations as complete as possible and keep a full record of their findings, making a report at the end of the period as to the number examined and the number of defects corrected.

A motion picture, "Working for Dear Life," and a set of lantern slides bearing on the subject will be available from the tuberculosis league.

The object of the campaign is to set people thinking about the importance of their health and to make them feel that it is as necessary to have a yearly health audit or examination as it is to have an examination of their automobile, industrial machinery or the books of

their business. Estimate has been made that if such an examination was made early and the difficulties found immediately remedied the span of life would be increased as much as twenty years.

The executive committee of the league has gone on record as opposing the reduction in the height of rooms in tenement houses from nine to eight feet, as proposed by Senate Bill No. 205.

Newark Vital Statistics.—There were 411 deaths reported during December, 1923, or a death rate of 11.2 per 1,000 population. The principal cause of death were: Tuberculosis, 35 cases; cancer, 27; apoplexy, 29; organic heart disease, 61; pneumonia, 54; Bright's disease, 25. There were 892 births during the month.

During the year 1923 there were 5,221 deaths or a death rate of 11.9 per 1,000. The total number of births was 11,111.

New Jersey Mortality Report.—During the month of November, 1923, there were 3,212 deaths; 408 were of children under one year of age, 141 of children over one and under five years and 1,252 deaths of persons aged sixty years and over. The death rate for the month was 11.12. There was an increase of deaths from typhoid fever, measles and pneumonia. The principle causes of death were: Measles, 11 cases; typhoid fever, 13; diphtheria, 34; tuberculosis, 231; cancer, 256; pneumonia, 168; Bright's disease, 276.

The Bureau of Venereal Disease Control of the State Department of Health has issued a pamphlet containing lectures on gonorrhea and syphilis, to be distributed to student nurses in the training schools throughout the State. The lecture on gonorrhea was given by Dr. C. C. Norris of Philadelphia in a Camden hospital and the one on syphilis by Dr. A. J. Casselman, consultant of the Bureau, in a Trenton hospital. The lectures on these subjects in the various training schools for nurses in the State have been asked to consider the points covered in the pamphlet in preparing their own lectures.

Less Deaths from Alcoholism.—Deaths from alcoholism in Philadelphia decreased more than eighty-five per cent. in the first six weeks of 1924, in comparison with a similar period last year, Frank Paul, chief investigator of the coronor's office, said recently. Mr. Paul attributed the reduction to Director of Public Safety Butler's campaign against law-breakers.

Reports showed 150 deaths due to alcohol during the first six weeks of 1923, Mr. Paul said. This year only twenty-seven have been reported and eleven of these were due to accidents resulting from intoxication.

Nutritional Problems of Children.—A Second Institute is being held in Newark as the Journal goes to press, conducted by Dr. W. R. P. Emerson of Boston, Mass., under the auspices of the New Jersey Tuberculosis League. The signs and causes of malnutrition as discovered by Dr. Emerson are: Signs—paleness,

lines under the eyes; mouth breathing; flabby muscles; round shoulders; projecting shoulder blades; stooping posture; curvative of spine and prominent abdomen. Nervous: Restless, "contrary," timid, frightful, inattentive and irritable. The causes are: Physical Defects—Such as adenoids, diseased tonsils, decayed teeth, defective eyesight. Lack of Home Control—Parents should guide and control their children. Over Fatigue—Late hours, over activity, too hard school and social programs. Faulty Food Habits—Eating irregularly, fast eating, too many sweets, tea and coffee, insufficient breakfast, too long between meals, not eating enough, improper food. Faulty Health Habits—Lack of fresh air and exercise, insufficient sleep and rest, and worry.

National Disease Control Measures.

Essential to the control of communicable disease are four measures: Medical treatment for the cure of cases; immunization of susceptible individuals when possible; discovery of carriers and supervision of infectious cases; and a campaign to instruct the public to seek prophylactic and curative treatment, to avoid contact and to demand effective health administration. They have been adopted with success by many municipalities in the control of smallpox, typhoid fever, and diphtheria. We see clearly enough the value of these several measures, and we apply them to the control of all communicable diseases except gonorrhea and syphilis.

Effective anti-venereal treatment and adequate facilities are available; active immunization is impossible because scientific research has failed to discover a method—two of the general measures, then, are not municipal health problems. But the discovery of infectious cases and the supervision of delinquent venereal patients are clearly local health board functions, duties which cannot be evaded by local health officials. The educational campaign to encourage adequate treatment, avoidance of exposure, and public approval of health department activities in both a local and a State function. The papers which follow define the province of local and State health officials.

Because venereal disease control began as a war-time activity, it has been considered a thing apart and not related to the control of other communicable diseases. This attitude has been an unfortunate one, for it has led health officials to neglect measures—the value of which has been demonstrated in the control of other communicable diseases—that are applicable to the control of gonorrhea and syphilis. Not until sanitarians look upon the problem of venereal disease control as essentially the same as that of other communicable disease control, will the public adopt a rational attitude toward the prevention of gonorrhea and syphilis.—From N. J. Public Health News, February.

New Jersey Doctors Join in Dinner.—Doctors of Warren and Hunterdon Counties joined with those of Easton, Pa., in a dinner given to Dr. Michler when he retired as chief surgeon in Easton Hospital last month.

MEDICAL EXAMINING BOARDS' REPORT

	Exam.	Passed.	Failed.
Dis. Columbia, Oct. 19	19	16	3
Florida, June	58	41	17
Hawaii, July	4	3	1
Idaho, October . . .	8	8	0
Maryland, June . . .	76	74	2
Mass., Sept.	39	18	21
Ohio, June	174	171	3
Porto Rico, Oct. . .	9	9	0
Rhode Island, July	9	8	1
New Jersey, June..	57	45	12
Michigan, October..	26	24	2
Missouri, Feb. . . .	129	114	15
So. Carolina, June..	33	33	0

Anti-Diphtheria Vaccine in Paris—A vaccine against diphtheria, invented by Dr. Jule Renault and Dr. Pierre Paul Levy, makes epidemics of that disease practically impossible, according to the report of results of their experiments, communicated to the Academy of Medicine. The vaccine, which is called "T plus A" and is injected subcutaneously, is hyper-neutralized and causes little inconvenience. Three hundred children treated with it were found to be completely immunized after three injections, it is said.

Personal Notes.

Dr. Alexander Marcy, Jr., Riverton, sends a very interesting letter from Nassau, Bahamas where he is regaining his health. He says "I am looking forward to returning to my home and work in the spring, fully restored and quite my old self again."

Dr. Berth S. Pollak, Secaucus, has been appointed by President Farrand of the National Tuberculosis Association as a member of the Committee to Study Conditions under which Sanatoria Should be Built and Operated.

Drs. Thomas P. Prout and H. H. Bowles Summit, addressed the local Rotary Club on the Welfare Bills in the Legislature. The club voted unanimously in favor of the bills.

Dr. Julian P. Linke, Plainfield, seriously injured his hip in a collision with another auto.

Dr. Martin J. Synnott, Montclair, recently left the city for a visit to Pinehurst, N. C.

Dr. David N. Shippee, Midvale, has resigned from the local Board of Health, after twenty years of service.

Dr. William Martin, Atlantic City, has a communication in the A. M. A. Jour., Feb. 2 page 412, on "Cramps in the Legs and Feet" as generally due to sciatic irritation or neuritis and says his practice is to treat such with the static wave current applied to the areas involved, together with some active method of producing hyperemia.

Dr. Charles I. Silk, Perth Amboy, in a note to Mr. F. B. Kilmer on his St. St. Peter Hospital Campaign for money sent his check for \$100 subscription to the fund.

Dr. Enoch Blackwell, Trenton, and wife visited Clinton, N. J., friends last month.

Dr. Harry J. Harp, Sussex, and wife, spent a week in New York last month.

Journal of The Medical Society of New Jersey

Published on

the First Day of Every Month



Under the Direction

of the Committee on Publication

Vol. XXI, No. 4

ORANGE, N. J., APR., 1924

Subscription, \$2.90 per Year
Single Copies, 25 Cents

COMPLICATIONS OF DIABETES IN PATIENTS UNDER INSULIN TREATMENT.*

By **Robert Emmet Allen, M.D.,**

Physiatric Institute, Morristown, N. J.
Morristown, N. J.

Long before insulin was discovered it was known that adequate treatment of diabetes mellitus could not be carried on without proper control of blood sugar. It was also known that inadequate treatment is little better than no treatment. The use of insulin has conclusively proven this. The purpose of this paper is not to repeat the simple known facts which are essential in the treatment of diabetes but to clear up some of the questions which have come to the minds of many who have been treating or have seen diabetes patients treated with the occurrence of complications in spite of the use of insulin. The complications which have occurred when patients have been taking insulin have led some physicians to believe that this new remedy is not only worthless but dangerous. In the hands of people who refuse to take adequate precautions in treatment, insulin is dangerous, but the proper precautions are so simple that a child of seven or eight years of age can be taught them.

The use of insulin has not changed the treatment of diabetes in any of its essentials. It does permit the patient to take a diet which will make him feel well and strong and thereby make a useful citizen instead of an invalid. Its use has made an accurately calculated and weighed diet more important than before, and this importance cannot be over-estimated. This new drug has also aided in saving the lives of patients in acidosis and coma who would have died had it not been obtainable, but the other

measures used in treating acidosis before insulin was available, are still as important as ever. The need for insulin depends entirely upon the severity of the disease and the diet which the patient will need to permit him to carry on his work, keep his strength, and maintain his weight at or slightly below normal for his stature and age. Overnutrition is unnecessary and often dangerous. Patients are easier to treat and in less danger of having either hypoglycemia or hyperglycemia if they are kept moderately undernourished and on a diet which will require the smallest doses of insulin possible to maintain their health and activities. It is not necessary to discuss the details of treatment of diabetes, for this has been done by numerous investigators and their opinions and methods can be read in numerous journals and text books..

Complications which occur under treatment are due either to insufficient treatment or to tissue damage which has occurred before adequate treatment has been instituted. They are: (1) Loss of tolerance, (2) infections, (3) acidosis, (4) arterial disease and subsequent damage to tissues from diminished blood supply, (5) neuritis. The knowledge that these are complications is not new and a full description can be found in most text-books on internal medicine.

Loss of tolerance was once thought to be a necessary accompaniment of the disease but this had been disproved by F. M. Allen before insulin was used. Loss of tolerance can be prevented if diabetes is properly controlled and the blood sugar kept at or very near normal at all times. Loss of tolerance can be considered a complication of diabetes because it occurs without treatment and is preventable. It is the most common complication and its prevention can be accomplished except in rare cases of progressive destruction of the pancreas, as in re-infections and cases of extensive sclerosis of pancreatic vessels, or calculi.

*Read before the Morris County Medical Society, December 11, 1923.

When insulin first came into use several specialists published statements that it was safer to allow a small amount of sugar to appear in the urine each day than to keep the urine sugar-free at all times. This statement was made to safeguard the patient against hypoglycemia and possible fatal accident. This statement was published in the pamphlet accompanying every bottle of insulin distributed and was read by all patients or those who were responsible for their care. It was not known at that time by the men who gave such advice that harm could come from it. At the same time those who had advocated absolute control of the blood sugar and abolition of glycosuria at all times kept their patients sugar-free with insulin and had no trouble. They promptly issued reports to the effect that even slight glycosuria was harmful and were able to back their statements with a little evidence. The evidence they now have is abundant to substantiate their position. The opposite policy is often responsible for acidosis and coma, slight or serious infections, gangrene and other complications involving disability or death. The physician in charge is not always responsible for these results. In spite of warnings which they have received and education regarding their condition a certain percentage of patients become careless after a few months and start to take liberties with their diet which they know their physician would not permit. They decide to eat a light breakfast, a light luncheon, and a heavy dinner and vary their insulin dosage in proportion to the change in diet. As a result the blood sugar is high either during the greater part of the day or throughout the entire day. Other patients have glycosuria on a diet and insulin dosage which had been properly adjusted before they increased in weight, but do not increase the dosage to meet the new requirement and are tardy in reporting to their physician for advice. There are hosts of excuses offered but often the damage has already been done before the patient returns for further advice.

The frequency of dosage is a problem which must be settled for each case. The most common method is to give three doses daily. Those requiring only small dosage can get along satisfactorily on two injections per day. Four injections daily are required in very severe cases to prevent the blood sugar from going high during the night and glycosuria occurring before breakfast. There are few cases requiring only a single daily dose. An injection only once per day, usually means the treatment

is unnecessary (i. e. the case is mild enough that diet alone would suffice) or inadequate (i. e. glycosuria or hyperglycemia is permitted). Insulin exerts a direct influence for only a few hours after injection. To have the blood sugar at a satisfactory level for only a few hours each day is unfair to patients, for it gives them a false sense of security and, when complications occur, destroys their confidence in their treatment and their physician.

Infections occur much more readily and are more severe and prolonged when the blood sugar is high. Such complications as frequent colds, tonsillitis, otitis media, boils, carbuncles, paronychia, pruritus, etc. occur and behave as in cases not under treatment. With them occurs a lowering of tolerance and, far too frequently, acidosis or septicemia follows. On the other hand, prompt thorough control of the blood sugar will bring about healing of the infection in as rapid a manner as would occur in patients without diabetes, providing treatment is not instituted too late. All that need remain are the scars, perhaps a permanent loss of tolerance, and a resolve to avoid further trouble.

Gangrene is not directly benefited by the use of insulin. If tissue destruction has not gone too far and the blood supply is sufficient to permit healing, proper control of the blood sugar, either with insulin or with diet alone, depending upon the severity of the case, will remove the effects of active diabetes upon tissue repair. These wounds then do well if kept cleansed, allowed free drainage, and spared the application of irritating drugs. On the other hand, if the blood supply to the affected part is not good, if the gangrene is very extensive, or if extensive infection is present, amputation at a point where the blood supply is sufficient to permit healing and where a good stump can be provided is as necessary as before insulin was obtainable.

After the patient has recovered from such a complication it is absolutely necessary to hold the disease under control by keeping the blood sugar near normal at all times in order to prevent or, at least, postpone as long as possible the return of gangrene in the same part or somewhere else. The appearance of gangrene should serve as a warning to the patient and to the physician in charge that there has been severe damage to the whole arterial system. It is not logical to believe, nor is it true that gangrene represents purely local damage to tissue. Examination of the palpable peripheral vessels and of the vessels in the eyes

will show quite conclusively that the vascular changes are general. A careful examination of the heart will commonly reveal an imperfect myocardium, and often there is more or less nephritis present. With this general sclerosis of blood vessels advanced to such a degree that gangrene of some part has occurred there is always danger of a recurrence at or near the first lesion, or another complication due to arterial disease somewhere else. Angina pectoris, intermittent claudication, neuro-retinitis, and occasional brain lesions occur as in arteriosclerosis due to anything else. Keeping diabetes under proper control at all times will not prevent arteriosclerosis, but there seems to be evidence that thorough treatment will slow such vascular disease down to the same rate of progress as occurs in non-diabetic adults. Most cases of gangrene and other complications of diabetes due to arterial disease occur in untreated cases or in cases which have kept fairly comfortable but allowed to excrete a little sugar and have consequently been having hyperglycemia for a long time, generally for many years.

Neuro-retinitis is as preventable as other complications if treatment is instituted in time. It occurs far too commonly and unilateral or total blindness may come gradually or without warning. The slow impairment of vision may be almost imperceptible, or no changes may be noticed until a severe hemorrhage has resulted and the sight is gone. The prognosis is always doubtful regarding return of vision and depends entirely upon the blood supply being good enough to permit of some absorption after the case is brought under proper treatment. Improvement is usually only partial when it can be brought about and may be only temporary. Such organic visual changes should not be confused with the rather alarming impairment of vision which occurs due to muscular weakness. This may happen under treatment and can be easily diagnosed by an ophthalmoscopic examination. It is distinctly transitory and will clear up without any change in the treatment planned. Occasionally it will persist over a period of two or three weeks and cause the patient and physician much worry, but allowing the blood sugar to again go high rarely helps and only delays treatment and invites trouble elsewhere.

For the good of the patient pain is too uncommon. If neuritis were more frequent the more serious complications could be more easily avoided, because the patient would seek medical aid sooner and would

be more anxious to keep his disease under control to prevent its return. Often neuritis occurs only after the disease has been present for some years and poorly cared for. In these cases there can often be found arterial changes as well. The patient is now ready to treat his disease seriously and abide by the treatment prescribed. Prompt reduction of the blood sugar and keeping it there by diet or diet plus insulin usually relieves neuritis in a short time, and the patient develops such a wholesome respect for his disease that he is careful about treatment. If the treatment is thorough the results are gratifying, but there is absolute necessity for keeping the blood sugar constantly below 160 mg. per 100 c.c. in most cases instead of merely keeping the urine sugar-free. The usual thing is to find a high kidney threshold for sugar in these cases of long standing diabetes and often, too, this threshold is permanently high although through treatment it may become lowered somewhat.

Another reason for keeping the blood sugar under control is that patients become lax in the tests of their urine and report that there has been no positive reaction for some time, when they really have been testing only once a day and usually these tests are found to be made at the most unlikely time to show sugar. Single tests are made in the morning before breakfast or in the evening before the evening meal. The most common findings of sugar, when patients are taking insulin, occur between breakfast and luncheon, or even before breakfast. Those not taking insulin excrete sugar most commonly in the evening. The test of the blood sugar will aid in correcting the error and serves as a lesson to the patient to be more careful. Under such circumstances we have seen numerous cases of neuritis occur. Patients complain of pains in the shoulders, back, arms, or legs, frequently worse at night, and correction of the blood sugar level usually quickly relieves the pain. A few patients have reported that they feel much stronger and are more able to work if their blood sugar is kept near normal. Two patients complained that they felt tired, lacked ambition, and were nervous when their blood sugar tests showed above 200 mg. per 100 c.c. An increase in the insulin dosage sufficient to bring the blood sugar down to about 150 mg. relieved them entirely. Both patients were slowly increasing in weight and a gradual increase in insulin dosage was necessary.

Fortunately most of the patients under

treatment with insulin are willing to be careful and serious accidents have not happened to many. The following resumes are taken from the records of cases which represent the different types of accidents which occur.

No. 1416—Male. Age 10. Admitted to Institute May 23, 1923. F. H. and P. H. neg.

P. I.—Symptoms of diabetes appeared in the latter part of December, 1921. He was treated by modified diet but the urine frequently showed sugar in varying amounts. Insulin was started May 25, 1923. At home the urine was kept constantly sugar-free and the blood sugar below 0.150% until September 28, 1923. Between September 28, 1923 and November 20, he proceeded to eat a little fruit which was not calculated in the daily diet. His weight increased $3\frac{1}{2}$ lbs. and the urine frequently showed traces of sugar. In the early part of November he had a severe cold and an abscess developed in the left nostril and did not heal. On November 20 the blood sugar was found to be 0.300%. Insulin was increased from 12 to 16 units daily, the small abscess began to heal, and on November 30 healing was complete and the blood sugar was 0.126%. Loss of tolerance from increase in weight and allowing the blood sugar to remain high too long resulted in a permanent insulin requirement of 18 units.

No. 543—Male. Age 11. Admitted to Institute May 19, 1923.

Had been taking insulin since April 3, 1923. On a diet of 100 gm. protein, 100 gm. carbohydrate, and 2000 calories, with 14 units insulin in two doses daily, there had been no glycosuria. The blood sugar had not been above 0.130% in any monthly test. September 1 he developed a small furuncle in the incisura intertragicum which slowly enlarged. The urine began to show traces of sugar and he was brought in for a blood test September 7. The blood sugar was 0.334%. The insulin was increased to 18 units and the abscess incised. The infection healed promptly and he was allowed to return to 14 units per day September 14. Since then his blood sugar has been below 0.130%.

In this case there was excellent interest shown by the parents and a loss of tolerance was prevented by prompt attention to the glycosuria.

No. 1105—Male. Age 38. First seen and admitted to Institute March 26, 1922. F. H. neg.

P. H.—Never very strong. Suggestive

attack of acute appendicitis in childhood. Pain, swelling, and abscess about left hip-joint at age of 3. Now has to wear elevated left shoe and has slight limitation of motion in the joint.

P. I.—Sudden onset of symptoms of diabetes in September, 1920. Modified diet kept him sugar-free for a short time and he has since shown no more than traces.

P. E.—Essentially neg. No demonstrable pulmonary Tbc.

He was able to take a diet of 55 gm. protein, 20 gm. carbohydrate, and 1600 calories, and remained fairly faithful until November, 1922, when he ate extra food. He corrected the diet when warned of the danger and was advised to take insulin in March, 1923. He was readmitted to the Institute March 17, 1923. He had a chronic cough for several weeks and the blood sugar was 0.395%. Sputum was negative for acid-fast bacilli. Chest exam. revealed only mild bronchitis which cleared up when the blood sugar was reduced. The diet was increased to 100 gm. protein, 100 gm. carbohydrates, and 2400 calories, with 64 units insulin. By August, 1923, his weight had increased from 104 to 125 lbs. and 100 units of insulin failed to control glycosuria. He was advised to re-enter to have the diet and insulin adjusted.

He was re-admitted September 11, 1923 with a blood sugar of 0.441%. He had a small abscess in the left thigh at the site of a former insulin injection. The abscess had been present for one week without any tendency to heal. He had had pain in the left axilla on inspiration for one week, feeling of lassitude in the afternoons, and cough in the evenings productive of a few white flecks. Examination revealed impaired resonance and harsh breath sounds over apices posteriorly, small amount of fluid at the left base, and coarse, dry crackles of pleuritic friction at both bases. The diet was reduced to 60 gm. protein, 40 gm. carbohydrates, and 2400 calories. On 90 units of insulin the blood sugar was 0.125% during digestion and the pleuritis and abscess cleared up in 3 weeks.

The chief difficulty in controlling this case is the patient's slight negligence and especially the severity of his diabetes which makes home management very difficult. The presence of tuberculosis, which is probably more or less active at different times, varies the insulin requirements and consequently close supervision is necessary at all times. There has been a definite loss in tolerance found each time he has been re-admitted and this can be attributed partly to infec-

tion but chiefly to the fact that the blood sugar has not been satisfactorily controlled

No. 541.—Female. Age 8. First seen and admitted to Institute May 11, 1921. F. H. and P. H. neg.

P. I.—Onset of symptoms of diabetes in December, 1920. Urine was found to contain sugar March 10, 1921. Was kept on very low diet for 7 weeks and then put on 5% and 10% vegetables, eggs, meats, and little fat. Urine frequently showed sugar after that and she ate additional food whenever possible.

After being put on a weighed diet she would eat additional food whenever she could get it and blood sugar varied between 0.200 and 0.500%. On March 10, 1923, she was put on a diet of 80 gm. protein, 80 gm. carbohydrate, and 1400 calories, with 27 units of insulin. She still continued to break diet and thus lost tolerance so that the insulin requirements rose to 42 units or more. Early in August, 1923, she had mild acidosis (polyuria, polydipsia, drowsiness, and hyperpnea). Parents treated her by giving nothing but the carbohydrate in the diet, forcing fluids, and 80 units insulin for two days. They were warned to use every effort to keep her strictly within the limits of her diet and give her enough insulin to keep the urine sugar-free at all times and thereby avoid another attack. The second attack of acidosis followed by otitis media occurred seven weeks later and was again treated by her father, and the final attack ended December 10, 1923, with death of the patient.

In this case the parent was responsible to a large degree, for he would not obtain proper medical aid at the onset of the emergency and was extremely tardy in bringing the child in for occasional tests. Whenever blood tests were made they were found to be at or above 0.275 per cent.

No. 1350.—Female. Age 5. First seen and admitted to Institute March 11, 1923. F. H. and P. H. neg.

P. I.—Symptoms of diabetes first noticed in summer of 1922. Glycosuria had been kept down to small amount by restriction of carbohydrate in diet. P. E.—Neg.

A diet of 80 gm. protein, 80 gm. carbohydrate, and 1800 calories was started, and the patient was discharged on March 30, 1923, with 8 units insulin to keep the fasting blood sugar below 0.150%. During April there was an increase of 10 lb. in weight and a rapid increase in insulin to control the glycosuria was advised. Patient and parents had read that a small amount of glycosuria was not harmful and were

careless about the diet. Early in August glycosuria became more marked and she suddenly developed acidosis and died August 16, 1923.

No. 2030.—Female. Age 11. First seen and admitted to institute February 26, 1923. F. H. and P. H. neg.

P. I.—Neg. except for mild diabetes for 2 years. Had been on a diet of restricted carbohydrate and had little glycosuria. This patient was discharged on a diet of 60 gm. protein, 25 gm. carbohydrate, and 1500 calories with a normal blood sugar. During the fall of 1923 she became careless about her diet and was re-admitted to the Institute with acute otitis media and acidosis. The otitis cleared up rapidly after the blood sugar was reduced. She had now a severe case requiring 60 units of insulin with a diet of 80 gm. protein, 80 gm. carbohydrate, and 1800 calories.

This case shows that whether or not insulin is used, unless the treatment is thorough, and the blood sugar is properly controlled, these complications will occur.

No. 1559.—Female. Age 59. First seen and admitted to Institute August 22, 1923.

F. H.—Mother and paternal cousin had diabetes.

P. H.—Dietary and carbohydrate excess for many years. Obese since age of 25.

P. I.—Indefinite onset,—probably before 1908, when she had weakness, blurring of vision, and ulceration of left 5th toe. In 1919 had dry gangrene of right middle toe with loss of distal one-third. In 1920 had gangrene of 2 toes of left foot, which resulted in some loss of tissue after four months. Since then feet have been cold and numb and occasionally she has had pains in them and in the ankles.

Was told at the age of 29 that she had "heart dropsy." Since 54 years of age has had edema of ankles, particularly during the day and dyspnea and palpitation on slight exertion. Left eye has cataract which has slowly developed during the past four years. Memory has been failing recently.

P. E.—(Essential points). Early cataract in left eye. Retinal vessels of right eye show moderate sclerosis. Lungs negative except for few moist crepitations at bases. Heart slightly enlarged to left; arch not widened; sounds were dull and of poor quality, soft systolic murmur at apex. Occasional ventricular extrasystole. Palpable vessels were slightly thickened. Blood pressure—130 systolic, 90 diastolic. Abdomen: heavy panniculus adiposus. Lax musculature. Liver edge palpable one finger-breath below costal margin. Small amount

of ascites. Extremities: Large white scar on dorsum of left foot. Half of left 2nd toe missing. Half of 3rd toe of right foot missing. Large callus on lateral side, opposite 5th metatarsal, of left foot.

The patient was put on a diet of 40 gm. protein, 20 gm. carbohydrate, and not over 400 calories daily. The blood sugar came down from 0.416% to 0.217% in 6 days, and the diet was increased to 50 gm. protein, 30 gm. carbohydrates, and 600 calories on August 30. On September 2nd insulin was started in doses of 5 units night and morning. The diet was not changed because of the necessity of reducing her weight. The blood sugar was allowed to remain between 0.230% and 0.250% during the rest of the month, in the expectation that it would come down gradually with loss of weight.

September 30, 1923, superficial gangrene developed on the ends of the first three toes of the right foot, first appearing as large blisters with cyanosis about the borders. On October 2nd a large blister appeared on the end of the right big toe. Insulin was promptly increased and the blood sugar was kept below 0.140% thereafter. Only superficial tissues of the ends of the toes involved, including the nails of both big toes were lost. The patient's confinement was prolonged on account of the gangrene.

This is a representative case of endarteritis where the vascular changes were evidently due to diabetes, and shows the extensive involvement of all vessels, including retinal arteries, radials, and arteries of the feet, with the possible sclerosis of cerebral vessels being responsible for her failure in memory. The heart muscle showed definite lack of tone which may well have been due to sclerosis of the coronaries.

The history and physical examination showed that the patient had had trouble from endarteritis for about five years, and this should have been sufficient to indicate the necessity of prompt reduction of blood sugar. There was no glycosuria after the first 36 hours of treatment. The urine showed a trace of sugar after noon of August 25th. But the urgency of more thorough treatment was not realized until we had a good example of what can happen when hyperglycemia is not controlled.

SUMMARY.

The well known complications of diabetes will occur in patients who are taking insulin if the blood sugar is not properly controlled. These complications are (1) loss of tolerance, (2) lowered resistance to infections,

(3) acidosis (and coma), (4) tissue damage due to endarteritis as evidenced usually by neuroretinitis, nephritis, peripheral gangrene, cerebral arteriosclerosis, and other results of arteriosclerosis, (5) neuritis. These conditions will occur in patients untreated or improperly treated, whether they are taking insulin or not, and are more liable to happen when insulin is used without proper control of the blood sugar, because the diet usually is far in excess of the patient's natural tolerance.

The use of an accurately calculated and weighed diet is, if possible, more important than ever before, because the insulin dosage can only be adjusted properly when the amounts of protein, fat, and carbohydrate are constant. With such a diet the blood sugar can be kept below 0.150% if the insulin is given in sufficient amounts and frequently enough.

Such complications are preventable if treatment is thorough before they occur. In older people who have severe vascular disease, the progression of endarteritis can be stopped or markedly slowed. The influence of diabetes upon the healing of such damaged tissue can be removed and healing will occur if the blood supply to the part is sufficient to permit healing.

Hypoglycemia has not been mentioned as a complication because it is a complication of treatment and not of the disease and is preventable if the patient's diet is constant and the insulin dosage has been adjusted. Mild reactions may occur with increases in tolerance, but occasional blood tests will enable the physician to predict them and thereby avoid them.

REFERENCES.

1. Allen, F. M., *Med. Clinics North America*, 6, 1922, No. 3.
2. Banting, F. G., Campbell, W. R., and Fletcher, A. A. Insulin in the Treatment of Diabetes Mellitus. *Jour. Metabolic Research*, Vol. II., Nos. 5-6, 1922.
3. Joslin, E. P., Insulin in Hospital and Home. *J. Metabolic Research*, Vol. II., Nos. 5-6, 1922.
4. Wilder, Russell M., Boothby, Walter M., Barborka, Clifford J., Kitchen, Herbert D., and Adams, Samuel F. Clinical Observations on Insulin. *J. Metabolic Research*, Vol. II., 5-6, 1922.
5. Williams, J. R. A Clinical Study of the Effects of Insulin in Severe Diabetes. *J. Metabolic Research*, Vol. II., Nos. 5-6, 1922.
6. Woodyat, R. T. The Clinical Use of Insulin. (*J. M. R.*, Nos. 5 and 6, 1922).
7. Allen, F. M., and Sherill, J. W. Clinical Observations With Insulin. *J. Metabolic Research*, Vol. II., Nos. 5-6, 1922.
8. Allen, F. M. The Influence of Fat and Total Calories on Diabetes and the Insulin Requirement, *J. Metabolic Research*, III., 61, 1923.

9. Sherrill, J. W. The Influence of Carbohydrate and Protein on Diabetes and the Insulin Requirements, J. Metabolic Research, III., 13, 1923.

RHINOPLASTY FROM AN ARTIST'S STANDPOINT.*

By Luis P. Berne, M. D.,
New York City.

The technic of plastic surgery has of late made such strides that it is rapidly coming to be regarded as an art peculiar to itself, and in a certain sense a subject apart from surgery in general.

Yet plastic surgery considered by itself, does not so greatly differ from general surgery. Rather should we regard it as general surgery "done small," bearing the same relation to that work which the exquisite perfection of the ivory miniature does to the great masterpieces upon canvas.

It is indeed very natural to compare plastic surgery to portraiture, especially miniature work, for when we speak of

plastic surgery we are also sure to be thinking in terms of the face alone.

Only a short time ago there was doubt in the minds of surgeons as to the propriety of interfering with any natural process which possessed no other purpose than improving the looks of the patient. In severe lacerations, burns, or other disfigurement of the face, the surgeon would devote his attention primarily to the healing of the wound, the cosmetic result being distinctly secondary.

The tendency on part of the medical profession has heretofore always been to discourage patients from having such operations performed and as a result the patient invariably had to seek aid from the "quacks" and "beauty specialists."

The purpose of the presentation this evening is to endeavor to bring home to the profession the realization that plastic surgery of the face is performed and can be performed by ethical surgeons in accordance with the modern standardized principles and teachings of surgery.

PLASTIC SURGERY OF THE FACE.—(Author's Classification)

Class A—NON-TRANSPLANTIVE		Class B—TRANSPLANTIVE	
Nose	Long	Nose	Depressed
	Wide Bridge		Absence of Part or Whole (Congenital or Acquired)
	Hooked—Beaked		
	Deflected		
	Bulbous		
	Unshapely Nostrils		
Ear	Rhinophyma	Ear	Absence of Part or Whole (Congenital or Acquired)
	Outstanding		
	Large (Helix or Lobe)		
	Cauliflower		
Eye-lids	Entropian	Eye-lids	Entropian
	Ectropian		Ectropian
	Ptosis		Absence of Part or Whole Eye-Bed—Absence of.
Mouth	Hair-Lip	Mouth	Crooked
	Thickened Lips		Part Missing
	Large (Wide)		
General	Scars:	General	Burns (Large)
	Ragged		Nevus (Large)
	Depressed		Neoplasms
	Elevated		
	Keloidal		
	Moles		
	Angioma (Lymph or Hema)		
	Port Wine Mark		
	Wrinkles (Face Lifting)		

*Read before the Hudson County Medical Society.

Tonight's presentation will be devoted mainly to the correction of deformities of the nose.

The nose is the most prominent and conspicuous feature of the face; it is the central fixed point about which all the other features of the face are arranged; upon it

tives of India and other non-Christian countries, is evidenced by the barbarous custom of mutilating the noses of captured enemies or of those upon whom they wished to revenge personal or family wrongs.

The rhinoplastic surgeon, no matter how great his technical skill, has no hope of at-



Fig. 1.—Long-beaked, tuberos nose, with a protruding upper lip and frenum. Before operation.



Fig. 2.—Long-beaked, tuberos nose, with a protruding upper lip and frenum. After operation.

the symmetry and regularity of the entire countenance depends.

That the importance of the nose in indicating the conformation and character of the face was recognized by the ancients and even up to a short time ago by the na-

taining the highest rank in his professional work unless added to his ability as a surgeon, he possesses a sense of beauty and of proportion, and an innate appreciation of the harmony which must exist among the separate parts of any given object in

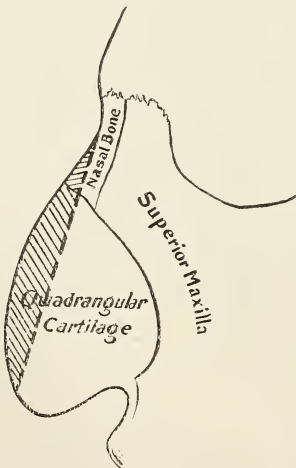


Fig. 3.—Dotted line and shaded area indicate the amount of redundant bone and cartilage excised.

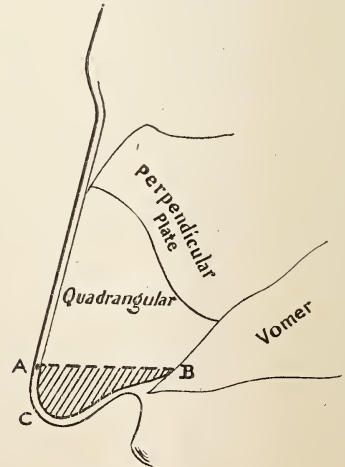


Fig. 4. Shaded area indicates the amount of shortening necessary for the reduction in the length of nose.

order to fuse it into a complete and satisfactory whole.

For "the surgeon who desires to distinguish himself in rhinoplasty" says Diefenbach, "should learn to model in clay and wax." Roberts affirms that "rhinoplasty not only involves manual dexterity on part of the operator, but a considerable degree of artistic training," while Roe classes the rhinoplastic surgeon with the artist, the sculptor, and the engineer.

In two reels of motion pictures the author demonstrated the technic employed in the correction of a markedly deflected nose, humped and elongated with unshapely nostrils. Every step of the operating, starting with the preparation of the patient and the field of operation, the removal of the hump, followed by the shortening of the nose, the narrowing of the base of the nose and the reshaping of the nostrils were all pictured. Likewise the practical use of the author's nasal rasp, the nasal forceps and the adjustable nasal clamp.

Upon an exact bony replica of the patient the author openly demonstrated the technic for the correction of the bony parts of the nose, showing how the frontal processes of the upper maxillae and nasal bones are sawed through. How a wedge piece of bone is sawed away from the wide and concave side (Fig 5), in order to equalize both sides.

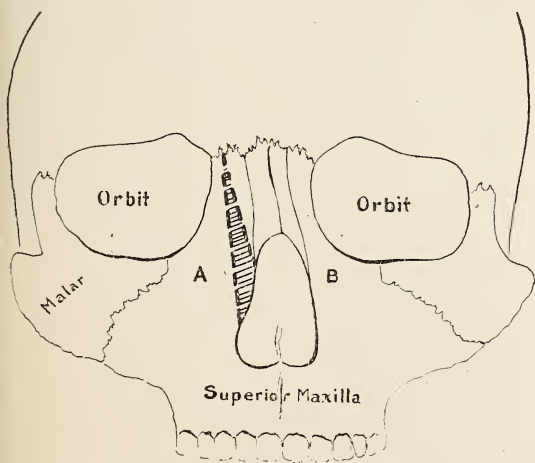


Fig. 5.—Deflected nose to left. A. Wide concave side of nose. B. Narrow convex side of nose. Shaded area indicates removal of triangular piece of bone from the frontal process of the superior maxilla of the wide and concave side.

The patient was shown immediately after operation for comparison with her appearance before the operation as well as six weeks after the operation.

In animated pictures, done by the author,

Dr. Berne depicted the technic employed in the correction of the bulbous nose. Showing how the wide and bowing tip of the nose is made narrow by the removal of a triangular piece of cartilage from the knee of the lower lateral cartilages. Then followed motion pictures and animated photography of the technic for the depressed nose, the author laying stress upon his modification of Joseph's operation for the transplantation of ivory.

Seventy lantern slides showed every type of deformity of the nose, the technic of same, with the results obtained after operation. Included in this was the depressed nose of which the author maintained there were twenty distinct varieties, every case requiring a special form of transplant. The author favored costal cartilage, but in properly selected cases, ivory is preferred because of the ease with which it is obtained. A great deal of experience and dexterity is necessary in the preparation of the model.

A few cases of partial and complete rhinoplasty were exhibited portraying the technic and the end results.

Dr. Berne concluded his presentation by saying that there is no other branch of operative surgery which demands more ingenuity, more patience, more forethought and more attention to minute detail, than rhinoplasty.

Spontaneous Rupture of Abdominal Wound.

Max Danzis, M.D., Newark, N. J.

A woman, aged 42, admitted to the Newark Beth Israel Hospital, September 18, 1918, had been operated on in a New York hospital, two or three years before, for some pelvic condition. This operation left her with a large ventral hernia. Since this operation she had been acting in the capacity of a practical nurse. While thus engaged, one day she felt the scar on her abdomen give away. She was brought to a physician's office, where omentum and intestines were found protruding from the abdomen, and she was transferred to hospital.

In attempting to free the adhesions, which were very extensive, from the skin, I noticed a small opening in the bowel. Continued separation resulted in further tears in the intestinal wall. It was noticed at this time that there was a tapeworm protruding from the proximal end of the torn intestine. About 15 feet of the worm was removed, but the head remained. About 3 feet of small bowel was resected, and end-to-end anastomosis was performed. A cigaret drain was inserted, and the abdomen closed by layer suture. There was considerable postoperative shock. Drainage was very slight. The wound healed on second intention, and the patient was discharged, October 16. She subsequently developed a large ventral hernia, which was repaired by a second operation, March 3, 1921. At present, she has a firm abdominal wall and is in perfect health.

TUBERCULOSIS IN CHILDHOOD.

By Murray H. Bass, M.D.,

Associate Pediatricist, Mount Sinai Hospital,
New York City.

I should like to speak to you tonight about certain phases of the subject of tuberculosis as it affects children. I shall confine myself to a small part of the subject, namely, the pathogenesis and diagnosis of pulmonary tuberculosis in children. Tuberculosis has become one of the most important subjects for the pediatricist's consideration for a number of reasons: First it is one of the common disorders affecting children; second, the frequency with which it affects adults, probably depends on the fact that during childhood, there is so marked a susceptibility; third, it was a pediatricist, Von Pirquet, who perfected the simple technic for discovering the presence of tuberculous disease. The past decade and a half has seen a real advance in our knowledge of tuberculosis in childhood owing not only to the discovery and application of the Von Pirquet test but also on account of the great strides which have been made in the development and use of the Roentgen rays in the diagnosis of the pulmonary form of the disease. Not only do the x-rays help in the diagnosis but they also enable us to follow the progress of a pulmonary lesion in a manner never before possible. Having at our command, therefore, so fine a method for following actual anatomical changes during life, and possessing in the dermal test so simple and yet so delicate a criterion as to the absence or presence of tubercle infection, it is not to be wondered at that great strides have been made in our knowledge of this subject.

Tuberculosis is of course of the greatest interest to all of us, whether we are general practitioners, surgeons, pediatricists or any other kind of specialist. However I do not think that it is generally enough realized that it is during childhood that the disease must be recognized in order that we should make a really successful fight in our campaign against tuberculosis. It is mainly upon those dealing with children then that the burden of the prevention of tuberculosis falls, and it is therefore of the greatest importance that all of us should be cog-

nizant of the best methods of detecting this disease in childhood.

Let us first consider the common course of an infection in childhood. Authorities are now pretty well agreed that infection most commonly occurs through the respiratory organs. The tubercle bacilli are inhaled and pass down the trachea and bronchi to lodge in the lung. Here they become surrounded with exudation and proliferation, forming the well known tubercle. This forms the so-called primary lesion, described by Ghon and his disciples in Vienna. This lesion is situated usually in the right lung, often in the upper part of the lower lobe where it may reveal itself as a very minute structure no bigger than a pin-head or may increase by proliferation of cells, or by breaking down and caseation to become as large as a cherry. The primary focus is usually single. Just as does an infected focus elsewhere in the body, so also in the lung does this focus give rise to secondary involvement of the regional lymph nodes. These nodes are the so-called bronchial lymph nodes, which become swollen, enlarged and finally also harbor the tubercle bacilli. It is important to realize that the process may and usually does stop at this point. We may therefore have simply a very minute focal lesion in the lung parenchyma,—so small as to be almost invisible to the naked eye, and secondarily find tuberculosis of the hilus nodes. The frequently minute character of the primary focus has resulted in the failure to locate it in many cases. I happened to be in Vienna in 1910 while Ghon, Hamburger and their associates were working on this problem and it was extremely interesting to see how very diligently this focus had to be looked for in many cases. The lung was sectioned into the thinnest kind of slices and the search over the surfaces of these sections was often carried on for hours before the focus would finally be discovered.

This is the commonest lesion which we find in the tuberculous child, and also, the simplest. However, if either the dose of the infecting organism is large or if for some reason the resistance of the child is lowered, the tuberculous process begins to spread. This spreading may occur in one of several ways,—if the lungs are the locus minoris resistentiae there is a direct extension outward from the hilus nodes and we get so-called hilus infiltration or root-tuberculosis. This is a very

*Read before the Passaic County Medical Society, January 10, 1924.

important type of lesion, because it is often difficult to diagnosticate. The process may stop here and the lesions cicatrize, or else it may spread further. Tuberculous material may enter the blood stream and produce either miliary pulmonary tuberculosis, or general miliary involvement of all the organs of the body. In these latter cases it is so often the involvement of the meninges which gives the important symptoms to the picture,—tuberculous meningitis. Instead of invading the blood stream the tubercle bacilli may be distributed through the lung possibly by way of the bronchi, giving us many patches of tuberculous broncho-pneumonia. Any of these pulmonary lesions may undergo caseation and softening with a resulting breaking down of smaller or larger areas of the lung. Any of these processes may moreover lead to secondary involvement elsewhere in the body. Thus the child may develop a kyphosis, a tuberculous joint, a tuberculous skin lesion, or an adenitis or a tuberculous kidney.

You will note that so far we have not spoken of phthisis,—of the chronic lesions so frequently seen in adults; of infiltration of the apex of the lung or of cavity formation. The reasons we have omitted this is that that type of lesion is rare in childhood. I shall be able to show you some radiographs of such cases, but the children showing these lesions are all of them above 10 years, in other words approaching adult age. Indeed so striking is the differentiation of lesions that the Vienna school has gone so far as to compare the stages of tuberculous infection with that of syphilitic infection. The primary lung focus and the hilus nodes correspond to the chancre and its adenopathy. Bone and joint tuberculosis and the miliary form correspond to the secondary stage of Lues; while phthisis,—the adult type of tuberculosis, corresponds to tertiary syphilis. The comparison is certainly an interesting one.

Before we discuss other portals of entry than the respiratory tract, it may be well to consider a little more closely the pathological relationship of the youthful form of tuberculosis to chronic phthisis. As most of you probably know, much work has been done on this subject and some of it in the laboratory.

The primary focus and the regional adenitis can be exactly reproduced by inoculation of a guinea pig with live tu-

bercle bacilli. If the bacilli are injected under the skin, a local ulceration takes place with swelling and caseation of the regional lymph nodes. The pig however never develops phthisis. Some investigators have however been able to reproduce the picture of phthisis by a reinoculation of the same animal at a latter date. May not the phthisis of the adult therefore, be due to a re-infection? Many facts seem to corroborate this hypothesis. For example in countries such as Chile, where there is very little tuberculous infection among children, there is also little chronic phthisis among the adult population. Apparently the early infection of tuberculosis in childhood puts the organism in such a condition that when later in life a re-infection occurs, that patient instead of developing another primary lesion, develops phthisis. It seems moreover that the first infection acts not only on the individuals general resistance, but on the lung itself, for investigators have shown that in an animal once infected, a second infection will cause phthisis whether the organism be introduced by the aerogenous or the hematogenous route,—that is, the lungs themselves seem to have developed a lessened resistance.

We have been speaking as if the aerogenous route were the only one by means of which the child becomes infected. This of course is not the case. There are other portals of entry,—the alimentary tract and in a few cases the tonsils. However all evidence points to the fact that here in America at least, the respiratory tract seems to be first affected in the great majority of cases. The same holds true for Germany and Austria, where all milk is boiled before being fed to infants. In Scotland however where there is very poor supervision over the health of cattle, and where milk is fed raw, there is much more tuberculosis of the intestines and abdominal glands and less of the pulmonary variety. In America pulmonary tuberculosis is almost exclusively caused by organisms of the human type and figures show that only 10 per cent. of the tuberculosis found among infants and children is due to bovine organisms. The probability is therefore strong that the child becomes infected from other human beings, usually from adults afflicted with the disease.

From what we have said about the pathology of tuberculosis it will be evi-

dent that a diagnosis from physical signs alone will often be a matter of great difficulty. It is therefore fortunate that just at the age when physical signs are of least value, namely, infancy, we possess a diagnostic aid of real significance.—that is to say tuberculin. I should like to spend a little time in discussing the rationale and value of tuberculin in the diagnosis of disease in children. The methods by which tuberculin may be used to greatest advantage are, I think, the cutaneous application, or Pirquet test, the intracutaneous injection, or Mantoux test, and last the subcutaneous injection. The first, that is the Pirquet test, in which the tuberculin is merely applied to the scarified skin, is certainly the simplest and easiest method to use. It is not the most delicate of the tuberculin tests, but is probably the most useful for the practitioner.

Given a child with a positive Pirquet test,—what conclusions may we draw? We may say that at some period of that child's existence it has been infected with tubercle bacilli and has reacted by the formation of tubercles. This has been very beautifully shown by Baldwin who proved that guinea-pigs never gave a positive reaction of tuberculin until anatomically tubercles could be proven. He placed various products of the tubercle bacilli in little parchment bags in the peritoneal cavity of the pig, but, although the toxins could osmose into the cavity, the animal never reacted to tuberculin. The tubercles may be produced by dead sterilized bacilli and yet reactivity of tuberculin will be present. So that in our child with a positive Pirquet test, we may predicate the presence of tubercles.

The skin test then shows only one thing namely a change in the cells of the child due to its having been at some previous time infected with tubercle bacilli. I say at some previous time because it has been shown that it takes about six weeks following the infection for the allergy to be developed by the body so it will react to tuberculin. This is well shown in the case of newly born infants whose mothers are suffering from open tuberculosis. Unless such infants are at once separated from the mother they become infected, though they do not develop positive skin reaction for four to six weeks. Since, as we know, the susceptibility of the human body to tuber-

culous infection varies with the age, the fact that an infant of three months gives a positive skin test, is quite a different thing from the standpoint of prognosis, from a child of five years who shows the same result. Since in the infant, resistance to the tubercle bacillus is very slight, we have as a result that tuberculous infection almost invariably means active tuberculous disease. We know of course by means of the skin tests, that as the children grow older more and more of them react to tuberculin until at the age of puberty, in some countries almost the whole of the population has been infected. Since, however, the resistance to the tubercle bacillus seems to increase with the age of the child, we are much less concerned with a positive tuberculin reaction in the older child.

By means of tuberculin tests we are enabled to gauge rather accurately how far tuberculous infection has invaded a community, and we are often amazed at the frequency with which positive reactions are encountered. As we said above, the cutaneous tuberculin test may be too delicate an instrument for us to use in telling whether a particular child is suffering from tuberculous disease, for when positive it may only signify a long-forgotten tuberculous infection which may have nothing whatever to do with the child's present complaint. However, when we are attempting to discover the frequency of tuberculous infection in the community, the cutaneous test is not sufficiently delicate. I was able to show this some years ago in attempting to find out how many children in a large child caring institution had been infected with tuberculosis. I proceeded as follows: I performed a Pirquet test on the child to be investigated. If this proved negative, I repeated it; if it again proved negative, I tested it a third time. If this still proved negative I used an intra dermal injection of 0.1 mg. of tuberculin. If this was negative I injected 1 milligram and again repeated this if it was negative. In other words no child was said to be free from infection until it had been subjected to six tests, three Von Pirquet and three intra dermal. My results were quite surprising, for whereas the Pirquet tests alone showed only ten per cent. of the children to have been infected, the intracutaneous test showed twenty-five per cent. Think of it, one quarter of the inmates of an institution

harboring supposedly healthy children under six years, had been infected with tubercle bacilli,—52 out of 206 children tested. These results moreover showed how much more delicate the intra dermal is than the cutaneous method. It also proved that if for scientific purposes we want to ascertain percentage of infection it will be necessary to make use of the most delicate test, namely the intra dermal.

In our medical practice, however, we only rarely need to call upon the intra dermal test, because it is too delicate a reaction. There are times, however, where the body's reactivity to tuberculin has been greatly lowered, as for example where the body is overwhelmed by disease, as in the miliary form of the disease. Here the body no longer reacts to the cutaneous test, but the delicate intracutaneous test will still be positive. Happ and Casparis at Johns Hopkins used the intracutaneous method in cases of miliary tuberculosis and found that whereas but 51 per cent. reacted to the Pirquet test, 87 per cent. reacted to the intracutaneous. Moreover they showed that when graded amounts of tuberculin was used, that is following the same method that I spoke of having myself used, they were able to get 100 per cent., of positive reactions provided they used a large enough dose. In our hospital work we use the Pirquet test first. If this is negative and we still believe that the condition may be tuberculous, but that the child is too ill to react, we inject intracutaneously 0.1 mg. If this is negative we inject 1 mg. In almost every case, a negative result here means that the condition is not due to tuberculosis.

The question is often raised as to the relationship of the size of a skin reaction to the severity of the disease,—thus does a large tuberculin reaction signify active disease? Opinions differ very decidedly on this question,—Pirquet believes the reaction is intense when infection is recent, or the disease has just started to progress; Calmette thinks an intense reaction means a recent infection where the defensive powers are good; Rozenblatt says that there is no relation at all between the disease and the reaction. There is one factor I think, however, which does influence the size of the skin reaction, if we are dealing with a so called scrophulus child we will find that we are likely to see very large re-

actions,—the thick-lipped child, prone to eczema and to swollen superficial lymph nodes, and respiratory catarrhal infections,—in short, the child with the exudative diathesis. Also children with bone and gland tuberculosis are apt to have large reactions. I think this an important point, because we might often be led astray in thinking that we were dealing with very active disease where in reality the size of the reaction may be due to the type of the child, more especially to the type of its skin.

I do not want to take up too much time and will therefore not go into detail concerning the subcutaneous test. Suffice it to say that we inject smaller amounts of tuberculin in children than we use in adults, say one-tenth, one-fifth, one-half, and one mg. for a child. We watch for the local reaction at the site of injection, the focal reaction at the site of the disease and the general reaction as shown by the temperature as in the adult.

In the infant and young child the pulmonary involvement is often of such a nature that the physical signs are not at all characteristic and in order to make the diagnosis of tuberculosis we have to look about for other aids. The tuberculin test is probably our most important help, but there are others. Given an infant that is doing poorly and whose weight is stationary, in whom we find no definite physical signs what should be our procedure? First of all let us not forget to suspect tuberculous disease in such an infant and not throw the case into the large category of "feeding cases." Many a tuberculous infant has had its formula changed again and again and has passed from one physician's hands to another's, always considered a feeding problem when it was the tuberculous disease which was retarding its gain in weight and interfering with its nutrition. After suspecting infection our first step is to inquire into the possibility of exposure. Has the baby been exposed to anyone suffering from pulmonary disease,—is there a tuberculous member in the family,—has any servant or boarder, or frequent visitor a cough? Such questions will often bring out a direct cause for the disease. A case in point is the incident described by Hess as having occurred in an infant asylum where it was customary to do Pirquet tests on all the inmates every six months. During one of these tests, he was astonished to find

an entire ward of infants giving positive reactions, whereas six months before they had all proven negative. On investigation it was found that one of the nurses in the ward had a cough which proved to be due to tuberculosis,—she had infected every child in the ward.

Beside the history, careful watch of the temperature may show that the baby is running continued though slight temperature. Cough is often a key to the situation, for enlarged bronchial nodes may give quite a characteristic type of cough. This has been called by Schick "the expiratory whoop." It is a brassy sounding rather high pitched short cough. Children with large nodes may however have pertussoid attacks of cough. Another diagnostic aid not sufficiently made use of are the skin manifestations, especially the so-called papulo-necrotic tuberculides. They are very characteristic and will sometimes make the diagnosis for you. I remember a case last summer that was brought to my service in the hospital from Ellis Island where the child had had measles. She had run temperature since that illness and had become somnolent. The question as to whether we were dealing with a tuberculous meningitis or a lethargic encephalitis could be settled at once by means of the tiny purplish brown papules, each tipped with a little scale, scattered over the child's back and legs. These skin lesions were absolutely characteristic and made the diagnosis of tuberculous infection certain, even before we had done a lumbar puncture. Tuberculides are small, about the size of a pin-head; they are brownish in color, somewhat shiny and often are tipped with a small scale.

In general miliary cases we are often baffled until an examination of the eye-grounds reveals the characteristic grayish-white circular or lentil-shaped tubercles scattered along the retinal vessels. Once seen these stamp the case as tuberculous. The eye may also help us to think of tuberculosis when we see phlyctenules. Although phlyctenular keratitis is probably not due to tuberculosis in every case, still Veeder and Hempelman in St. Louis found as large as 92 per cent. of cases of this disease reacting positively to the Pirquet test.

In conclusion I should like to show you a series of lantern slides illustrating the various forms of tuberculous disease as it affects the lungs of children.

FOCAL INFECTION IN RELATION TO PULMONARY TUBERCULOSIS.*

By **G. Reese Satterlee, M.D.,**
New York.

My objective is not to demonstrate the frequency of focal infection, but rather its relationship to systemic disease and particularly to tuberculosis. The importance of infections mixed with the bacillus tuberculosis is readily appreciated, having been well known for years, but the far reaching effects of so-called minor infections, the painless areas that are frequently found in the teeth and the underlying bony tissues, in the tonsils, the nasal sinuses, cervix, uterus, rectum, appendix, gall bladder and seminal vesicles is very frequently under-estimated. By focal infection is meant localized collections of bacteria and their products. These arise either directly from the bacteria themselves or as a result of the breaking down of the local areas of tissue in immediate proximity to them. Focal infections are caused principally by the streptococcus but they frequently contain other bacteria, notably the staphylococcus, pneumococcus and pathogenic forms of the colon bacillus. These infections are most frequently found in the teeth and tonsils. The conditions usually encountered in and about the teeth are: abscesses, granulomata, apical absorption, cysts, pericemental and alveolar absorption, pyorrhea pockets and osteomyelitic areas. The most frequent lesion of the sac type found in our experience is the cyst. This probably originates from an acute abscess which has not been drained or from a chronic abscess verging into a granuloma and finally becoming cystic. The evidence of these lesions is shown most effectively by the x-ray. Many teeth appearing normal under the physical tests shown degeneration on the films. It is necessary therefore, to have a complete x-ray study of all the teeth, and they should be re-filmed at least once every year. Apical absorption is frequently the only evidence of infection and when present the teeth should be extracted. The argument is frequently advanced that all these conditions may be present without symptoms, either general or oral, and that, therefore, they should be disregarded. This, however, is not a logical stand, for we have observed many patients⁽¹⁾ in whom such conditions have existed for years before definite symptoms, proven to be due

*Read before the New Jersey Sanatorium Association, January 18, 1924.

to them, have occurred. In other words, very little is now known of the relationship between focal infection and immunity.⁽²⁾

The infection in the tonsils usually consists of a collection of pus in the tonsillar crypts; occasionally it is deep-seated in the tissue of the tonsil itself. In this case there is often no external evidence of infection. In our own experience we have in no less than three cases found encapsulated abscesses which gave no outward manifestation whatsoever. Classifying the tonsillar conditions one may consider chronic infection with large hypertrophied tonsils (rare in adults); moderately large infected tonsils; small buried tonsils (very frequently overlooked); tonsils scarred by x-ray treatment or by previous incomplete operation; cautery, etc. (very difficult of removal); infected tonsillar stumps. The general practitioner with a little experience can recognize most of these types. It is frequently necessary to squeeze the tonsil against the bony prominences in order to elicit retained pus which usually will well out after such treatment. The appearance of the pharyngeal fauces is of very great practical value. If the anterior pillars show a deep purplish color it may be very safely assumed that there is infection behind them and that a most particular examination should be made.

The next most frequent seat of infection in women is the cervix uteri. From this primary focus the bacteria and their products gain access to the intra-pelvic organs via the lymphatics of the broad ligaments.⁽³⁾ They cause pus pockets or cellulitis in the tissue of the adnexae and occasionally of the uterus itself. The rectum is the next most frequent seat of infection. Whenever hemorrhoids exist infection is likely to collect in small pockets and in the cellular tissue underneath the mucous membrane; a condition usually known as proctitis. It is generally conceded that secondary infections from these so-called primary foci may occur in other organs, notably the gall bladder, appendix, bronchial tract, accessory nasal and mastoid sinuses.

Unfortunately, we are unable as yet to prevent the occurrence of either the primary or secondary infections in the majority of instances. A heartening exception to this is in relation to the teeth where modern prophylaxis applied at least once a month throughout the child's life has undoubtedly resulted in untold good and has great promise for the future. However, to day we are dealing necessarily with more or less terminal conditions and we are there-

fore obliged to remove the focal infections whenever and wherever found, leaving prevention to the future.⁽⁴⁾ This removal unfortunately is never thorough bacteriologically speaking and progress will come only by continued clinical work and by the aid from animal experimentations.

It is not in my province today to prove the relation of focal infection to systemic disease or to evaluate its removal. It is necessary to accept as proven the fundamental principles which, originating largely with Pasteur, have brought the modern conception that bacteria and their products are to be looked upon as the primary cause of disease. The tuberculosis bacillus has been accepted as the cause of tuberculosis and the streptococcus in its varied forms has long since been accepted as causing certain diseased conditions such as sepsis, cellulitis of all types, endocarditis and others. These conditions are, however, acute or subacute and present vastly different phenomena than those which are grouped under the term focal infection. This condition is a very chronic and a painless one and was probably first brought into prominence by the work of Adami⁽⁵⁾ who described it as a "sub-infection." The streptococcus, it must be remembered, is a generic term referring to a great many different strains which, while morphologically indistinguishable, have many different types of cultural and pathogenic characteristics. The importance and character of these has been as yet only partially studied, but this work will constitute much of the future progress of medicine. The tuberculosis bacilli fortunately have a marked tendency to localize in certain areas of the body so that the disease called tuberculosis has a natural trend toward healing. The streptococcus on the other hand, except under favorable conditions, hereafter alluded to, shows a tendency to spread. This would occur more frequently were it not for the fact that the bacteria are often confined in bony areas such as tooth sockets where they are surrounded more or less by impervious bone. The value of this bone jacket is more easily understood when the severe reactions are noted after its injury following the surgical removal of osteomyelitic foci. After this removal the bacteria and their products enter the circulation and frequently cause a profound sepsis. Fortunately, however, this is usually a toxemia rather than a bacteremia.

Toxemias.—We are just beginning to realize the importance of toxemias. The term is necessarily a general one owing to

the evanescent character of these highly poisonous, but little understood, chemical products. The toxemia resulting from dental infections, as indeed from others, may arise from at least three different sources; first from the elaboration of toxic products of the bacteria themselves; second, from the absorption of the toxic products from the tissues which are broken down by the bacteria; and third, as described in a recent volume by W. A. Price⁽⁶⁾ from a toxic substance elaborated in certain teeth that have been devitalized and which present apparently no bacterial infection. The symptomatology of these toxemias of whatever nature cannot be discussed here in detail. It suffices to say that those of the staphylococcus and of the colon bacillus, for instance, are very similar. Probably it is for this reason that the diagnosis of the primary infection is frequently overlooked. In order to clarify the situation, we have found it convenient to recognize three general classes. First are those in which there is danger of a mistaken diagnosis because of the inactivity of the tuberculosis. This class may be a small one. The second class is probably much more frequent. It is characterized by the presence of aggravated symptoms of tuberculosis which has been brought about by the unrecognized toxemia from focal infections usually of oral or pelvic origin. The third class comprises those having prolonged convalescence after the tuberculosis is apparently arrested. These latter classes can readily merge into each other and are certain to be very obscure as regards interpretation unless a proper study of the entire individual is made. This leads to careful detailed findings and therefore to a more refined diagnosis.

Cases Resembling Pulmonary Tuberculosis.—Evidence of focal infection but no tuberculosis.

Case 1.—Nurse, Fordham Hospital. Sick three weeks in bed with temperature of 100-101, cough, bloody sputum, containing no tubercle bacillus. X-ray of chest negative for tuberculosis; enlarged hilus shadows. Tonsils previously removed but infected stumps. With removal of infected stumps symptoms subsided.

Case 4772.—Male, age 30; accountant. Rejected for foreign service by Oil Company; said to be threatened with tuberculosis. Undernourished, underweight, cervical adenitis, enlarged spleen. Examination showed infected teeth and tonsils. Tonsillectomy and removal of dental infection; showed marked improvement in one month.

Gained 10 pounds; five months gained 8 pounds more. Adenitis and enlarged spleen disappeared; efficiency regained.

Case 5009.—Female, age 39, cough and symptoms of bronchitis, no evidence of pulmonary tuberculosis, extraction of badly infected teeth, resulted in complete recovery.

Case 5265.—Female, age 43, patient was studied for tuberculosis at Clifton Springs and Saranac Lake off and on for five years. Tuberculosis suspect—our diagnosis was toxic neurasthenia, chronic intestinal invalidism. Infected tonsils, infected cervix, hemorrhoids. Removal of these foci of infection resulted in a disappearance of symptoms. Tuberculosis had been excluded at Saranac Lake.

Case Showing Positive Pulmonary Tuberculosis, but aggravation of symptoms due to focal infections.

Case 5086.—Male, age 32, pulmonary tuberculosis for three years. Examination shows chest nearly negative. Past history—has always been subject to some infection. Chorea at 10. Always nervous. Tonsillectomy early in life. Attacks of indigestion, occasional nausea and vomiting, bilious attacks, hemorrhoids, dry skin and eczema. This patient is completely unfit for work on account of focal infection in the teeth and stumps of tonsils and infected antrum. There are also symptoms of gall bladder disease. The treatment in this case consisted in operation on the antrum, enucleation of tonsils. Patient had had about three years' previous treatment for tuberculosis but was unimproved. The conditions were so advanced that so far no brilliant results have been reported.

Case 4442.—Male, age 56. This is a very frequent condition of lumbago due to osteomyelitis of the jaw following dental extraction. Tuberculosis is advanced but quiescent. The essential treatment is to have proper oral surgery with removal of diseased areas of jaw bone during the rest for tuberculosis. The neuritis continued for a year because of lack of proper oral surgery.

Case Showing the Relation of Asthma and Focal Infection.

Case 4207.—Female, age 39. Severe asthma and constipation for ten years; chronic intestinal invalid. Had been treated from various angles including protein reactions. Lesions found were infected tonsils, hemorrhoids, pericolitis and constipation. The treatment was removal of foci, the tonsils, hemorrhoids, vaccines and anticolon and streptococcus serum. Result was

marked improvement after six months. The asthma had nearly disappeared. This was a colon and streptococcus toxemia.

Case Showing the Result of Removal of Focal Infection in Syphilis.

Case 4277.—Male, age 41. Old syphilitic, symptoms of syphilis, myocarditis, hepatitis and nephritis for seven years. Anti-syphilitic treatment for four years. Marked general improvement, but Wassermann still a four plus reaction. Very marked dental infection and infected tonsils then removed. Result marked improvement following removal of focal infections and Wassermann changed from four plus to one plus without anti-syphilitic treatment in the interim of three months. This case is similar to several others and it shows the improvement that careful removal of foci of infection in syphilis, demonstrating that there must be a marked inter-relationship in these T. B. infections complicated by focal infections.

There are of course numerous other disorders directly attributable to focal infections which may or may not be connected with tuberculosis. Such conditions include kidney disorders, notably nephritis and some of the obscure hematurias;⁽⁷⁾ colon disorders, gastric and duodenal ulcers, toxic or so-called functional psychoses, so-called neurasthenia, many acute dementias, all the arthritides, endocarditis, myocarditis, segmentally infected colons with or without constipation, headaches, particularly of the migraine type, appendicitis, proctitis, an increasing number of ocular disorders, such as corneal ulcers, iritis, retinitis and undoubtedly glaucoma. All these conditions frequently co-exist with pulmonary tuberculosis, in which case the surgical removal of the focal infections is mandatory.

Having demonstrated some of the ordinary conditions which are caused by focal infection and having detailed the results of treatment and the close inter-relationship of the causative foci, it is logical to conclude that all infections, particularly those of a chronic nature, constitute a serious menace and should be so far as possible eliminated from the human body.

It is necessary therefore for the modern treatment of all chronic invalids that they be studied by means of a proper equipment for the detection of the focal infection, especially those occurring in the oral region. This involves first a thoroughly competent oral surgeon; second, the preparation and proper interpretation of dental and sinus x-ray films. A routine examination of all patients, especially after the acute stages

of tuberculosis have subsided, is not complete except when the dental work has been followed by a thorough examination by a competent throat specialist. There is no reason why the two positions of internist and tuberculosis expert should not be joined in the same individual, but no one man can expect or should try to do it all.

Operative Procedures.—Even minor operations may sometimes give rise to serious results in the course of pulmonary tuberculosis. It is therefore necessary to exert the greatest precaution in advising the removal of dental or other infection and in choosing the time at which it should be done. These operations should be performed only by experts. Next, the importance of local anaesthesia. Nearly all of the dental extractions, simple or surgical, should be performed when possible under local anaesthesia. Other operations, such as enucleation of cervix, laparotomy, etc., will need a general anaesthesia. The decision is sometimes difficult to make but the general anaesthesia may be safe when the tuberculosis is very chronic.

The Time of Election of Operation for Focal Infection.—As many of these patients are invalids because of their focal infections and the length of time of curing for tuberculosis is long these minor operations should be done during this rest period. This is truly an economic problem. In cases simulating tuberculosis but where tuberculosis has been eliminated and the diagnosis of focal infection made, these patients can be treated in the sanatorium instead of elsewhere, provided proper facilities exist. It has been proved that rest alone does not cure conditions due to focal infections, but that rest after their removal is imperative.

Bad Results.—One of the great objections to this sort of work is the apparent danger from stirring up these old infected processes. This danger has undoubtedly deterred many physicians from "cleaning house" for patients in their sanatoria. A few bad results at the start may be very unfortunate; pneumonia has been known to follow tonsillectomy (usually due to general anaesthesia). These bad results, however, may occur with numerous other physical disabilities. I quote Dr. Weston A. Price⁽⁸⁾ "Rise of temperature perhaps with a bound, following extraction of an infected tooth occasionally seems to mark a development of a progressive infection, terminating fatally. This type of reaction will not infrequently be seen associated with the removal of teeth with marked gingival infections rather than periapical." The an-

swer to this difficult and preplexing situation is extreme care in extracting the tooth in a tuberculous patient, particularly in damaging the gingival borders. Frequently the fatal results that have occurred were in patients in advanced disease. Gradual immunity can be achieved by conservative, careful surgery as exemplified by the removal of one tooth at a time. In general, we consider it a safe and satisfactory rule to proceed to the detoxication of the patient by the removal of the various foci just as soon as in the opinion of expert and competent operators it is deemed expedient.

CONCLUSIONS:

- 1.—General recognition of the danger of infection constitutes the most important medical progress of the past decade.
- 2.—Focal infection causes symptoms which may easily be mistaken for tuberculosis.
- 3.—The frequent association of focal infection with tuberculosis prolongs convalescence.
- 4.—Removal of focal infections shortens convalescence and is of great economic value.
- 5.—All sanatoria should be equipped for the detection and removal of focal infection.

REFERENCES:

- 1.—Satterlee, G. R., Medical Record, Mar. 11, 1922.
- 2.—Danysz, J., *Evol. of Disease*, 1921.
- 3.—Sturmdorf, A., *Trans. Sect. Obstet. & Gynec. & Abdom. Surg. A. M. A.*, 1917, pp. 42-53.
- 4.—Draper, J. W., Medical Record, Mar. 11, 1922.
- 5.—Adami, J. R., *Col. Med. Journ.*, Denver, 1914, pp. 34-49.
- 6.—Price, Weston A., *Dental Infections, Oral & Systemic*, 1923.
- 7.—Satterlee, G. R., *Sect. on Stomatology, A.M.A.*, July, 1923 (to be published).

A FURTHER REPORT ON THE KAHN AND WASSERMANN TESTS OF BLOOD SERUM AND SPINAL FLUID.*

By **John F. Anderson, M. D., and
Emily B. Fischer.**

New Brunswick, N. J.

In a previous paper¹ we reported comparative results of Wassermann tests and Kahn tests on three hundred twenty-nine sera and on one hundred seventy-seven

spinal fluids done at the laboratory of the New Jersey State Hospital at Trenton. We have since tested four hundred twenty-nine additional sera and two hundred sixty additional spinal fluids each with the Wassermann test and with the Kahn test to get a further comparison of results of the two tests. With two exceptions, our procedure was identical with that used in the previous series of tests. We used a new antigen prepared, however, in the same manner as the old antigen. We used 1 c. c. of spinal fluid in the Kahn test set up instead of 6 c. c. which was the amount we had used in the previous series. We used in general the method for the precipitation tests as described by Keim and Wile,² which follows the method of Kahn.³

The antigens were prepared from dried fresh beef heart muscle finely broken up. Fifty grams of this material was placed in a five hundred cubic centimeter Erlenmeyer flask, covered with an inch of ether and placed in the ice-box. After twenty-four hours extraction the ether was yellow; it was poured off and replaced with fresh ether. This was repeated daily for three days. On the fourth day the supernatant ether was water clear. The ether was filtered off and the dried muscle spread out on paper and dried at room temperature until no odor of ether was detectable. To twenty grams of this material was added one hundred cubic centimeters of 95 per cent. alcohol and the whole extracted for nine days in the ice-box and one day at room temperature. The alcoholic extract was then filtered off. Twenty-five cubic centimeters of this was used as a plain alcoholic antigen. To another twenty-five cubic centimeters of it were added one hundred milligrams of cholesterol.

In the work here reported readings of the Kahn test will be readings of the cholesterolized antigen. A discussion of results with the plain antigen as compared with results with the cholesterolized antigen will also be given. The cholesterolized antigen was used in a dilution of one part antigen to three parts physiologic sodium chloride solution. The plain alcohol antigen was used in a dilution of one part antigen to two parts of physiologic sodium chloride solution. The mixtures were clear and opalescent. They were always used within an hour after dilution. The dilutions were made by rapidly adding the saline to the measured quantity of antigen. It seems important that the antigen be diluted in just this manner. The serum was

*From the Laboratory of the New Jersey State Hospital, Trenton, N. J.

always inactivated for twenty minutes on the day the tests were performed.

The set-up of the tests was as follows: Three-tenths cubic centimeter of serum was measured into each of three tubes about seven centimeters high, one centimeter diameter. To the first tube was added .05 c. c. of saline. This was the serum control. To the second tube was added .05 c. c. of the plain antigen dilution. To the third tube was added .05 c. c. of the cholesterinized antigen dilution.

The racks of tubes were vigorously shaken for three minutes and then placed in the incubator at 37.5° c. The following morning the tests were read. The results were recorded as follows:

— negative precipitation.

++++ a precipitate of one or more large clumps floating in the serum.

+++ one large clump or two rather large ones.

++ moderate sized flocculi.

+ small flocculi.

(+) fine flocculi (this is a doubtful reaction).

The precipitate is definite so that the results are not at all obscure. The clumps would break up into fine flocculi or granules when shaken. Sometimes in the tests there would be a white suspension near the top of the fluid which differed from the clumps and flocculi in that it disappeared on shaking. There was no mistaking it for a positive precipitation. Hemolysis in a serum did not seem to interfere with the test although in one case where the serum gave a ++++ Wassermann and the Kahn test was negative, the serum had a large amount of hemolysis. If a serum was very cloudy it could not be read, but if only slightly cloudy it could be. Spontaneous (immediate) positive precipitation tests were occasionally noticed but were not recorded. The Kahn tests and the Wassermann tests were done on the same day.

A cholesterinized human heart antigen was used in the Wassermann tests; they were fixed in a water bath at 37.5° c. for one hour and they were read after an overnight period in the ice-box. Of the four hundred twenty-nine sera tested with both the Wassermann and Kahn tests, there was agreement between the two tests in 90.2 per cent. One hundred and eighty-four of the four hundred and twenty-nine sera showed some degree of positive reaction in one test or both. Of these, there was agreement between the two tests in 71.1 per cent. One hundred and forty-six of the four hundred and twenty-nine sera were from

syphilitics under arsphenamine treatment. Of these, one hundred and forty-six sera, there was agreement in the result of the two tests in 77.3 per cent. One hundred and forty-one of the one hundred and forty-six sera from syphilitics under arsphenamine treatment showed some degree of positive reaction in one test or both. Of these there was agreement between the two tests in 78 per cent. Two hundred and eighty-three of the four hundred and twenty-nine sera were from new admissions at the hospital. Of these, there was agreement in the results of the two tests in 96.8 per cent. Forty-three of the two hundred and eighty-three sera showed some degree of positive reaction in one test or both. Of these, forty-three, there was agreement in the results of the two tests in seventy-nine per cent. The percents of agreement as above noted are in each case a little lower than the corresponding percents in our previous report, the difference ranging from .1 per cent to 2.9 per cent.

The sera from the syphilitics was always one day older when tested than that from the new admissions. Whether the age of the serum makes the Kahn test weaker we do not know. Although we had some positive Kahn test reactions with the plain alcoholic antigen, they were often weaker than the reactions with the cholesterinized antigen.

Kahn test reactions were performed parallel with the Wassermann on two hundred and sixty spinal fluids. These also were from syphilitics and new admissions at the hospital—in fact from some of the same people from whom the sera came. The tests were performed in the same way as the serum tests except that one c. c. of spinal fluid was used. In the previously reported comparative series of tests we used .6 c. c. of spinal fluid. We thought then that if we had used more spinal fluid there might have been a higher percentage of agreement between the two tests. The percentage was 68.3 in the first series. However, the percentage of agreement in this series of comparative tests, using one c. c. of spinal fluid, was lower than 68.3 per cent. Of the two hundred and sixty spinal fluid tests with both the Wassermann and Kahn tests there was agreement between the two tests in 64.8 per cent. One hundred and twenty-five of the two hundred and sixty spinal fluids showed some degree of positive reaction in one test or both. Of these, there was agreement between the two tests in only 26.4 per cent. Ninety-seven of the two hundred and sixty spinal fluids

were from syphilitics under arsphenamine treatment. Two of these were negative to both tests. Of the ninety-seven, there was agreement between the two tests in only 21.6 per cent. One hundred and sixty-three of the two hundred and sixty spinal fluids were from new admissions at the hospital. Of these, there was agreement between the two tests in 96.3 per cent. However of these one hundred and sixty-three spinal fluids, from new admissions at the hospital, only thirty showed some degree of positive reaction in one test or both; and, of these thirty, there was agreement between the two tests in 46.6 per cent.

In the spinal fluid comparative tests it was always the Kahn test that showed the weaker reaction of the two. Also, in the comparative tests on sera there were more sera where the Kahn test was weaker than the Wassermann test, than sera where the Wassermann test was weaker than the Kahn test.

From this series of comparative Wassermann and Kahn tests we conclude that the Kahn test may have possibilities of being a simple, direct, readily standardized method for serological diagnosis of syphilis. We are doubtful as to whether it will ever be satisfactory as a spinal fluid test for syphilis. We would want to see it more thoroughly worked out and tried, before we used it to replace a test as reliable as the Wassermann.*

REFERENCES.

1. Anderson, John F., Fischer, Emily E., "A Comparison of the Wasserman and Kahn Tests in Three Hundred and Twenty-nine Cases," New York Medical Journal and Medical Record, October 17, 1923.

2. Keim, Harther L., Wile, Udo, J., "The Kahn Precipitation Test in the Diagnosis of Syphilis," Journal of American Medical Association, 78; 870 (September 9, 1922).

3. Kahn, R. L., "A Simple Quantitative Precipitation Reaction for Syphilis," Michigan Department of Health, Reprint Series Nos. 9, 10 and 11, (January, 1923).

*The authors wish to acknowledge the interest and co-operation of Dr. Henry A. Cotton, Medical Director of the New Jersey State Hospital in this work.

The Old-Time Physician.

Tho' the future may flout them and scout them,

The world had been sadder without them;
Tho' they rest in their graves without glory,
Tho' they live not in song nor in story,
No prophet—no priest—had a mission
More Sacred thro' all the dumb years
Than that of the old-time physician,
Whose dust we bedew with our tears.

—Dr. James Newton Mathews.

County Medical Societies' Reports

BERGEN COUNTY.

Frederick S. Hallett, M. D., Reporter.

The regular monthly meeting of the Bergen County Medical Society was held at the Hackensack Hospital, March 11th, at 8.30 P. M. The president, Dr. G. L. Edwards, in the chair, with 35 members present.

The regular order of business was omitted and the Chairman of the Scientific Committee introduced Dr. Ernest A. May, of the Metcalf Foundation, who gave a very interesting talk on "Deep X-Ray Therapy" and after discussion the meeting adjourned to a social session.

HUDSON COUNTY.

Wm. Freile, M.D., F.A.C.S., Reporter.

The Hudson County Society held its monthly meeting on March 4th in the Nurses' Home Auditorium, City Hospital, Jersey City.

Dr. Pollak, reporting for the Welfare Committee, referred to the delegation at Trenton, mentioned that Bill 159 had but a slim chance; he felt that in these matters the committee should have more emphatic support from the Society.

Dr. S. A. Cosgrove reported that the Society had been incorporated; that the sub-committee on site had several locations in view; that the Dental Society had been interviewed by Dr. F. J. McLaughlin, with a view of interesting them; that the bond subscription would be ready in a short time and that something would probably be done at the next meeting.

Dr. Cosgrove had a copy of the original charter, which he had framed and presented to the Society.

The Banquet Committee reported a balance of \$113.60, which they had turned over to the treasurer.

The amendment to the Constitution and By-Laws, authorizing the yearly appointment of a Legislative Committee (instead of election for a series of years, as heretofore), was passed.

Dr. Robert T. Morris of New York City gave an interesting talk on "Worthless Appendix Operations." Some of the salient points he emphasized were:

Among acute abdominal conditions a diagnosis of appendicitis is readily made and there are comparatively few mistakes today. Sometimes one will be deceived by a case of ovarian abscess or tubal disease or even by a case of pneumonia in the early stages with pain referred to the appendix region. It is in cases of chronic appendicitis, not the acute ones, that the mistakes are most often made and the larger number of worthless operations done.

We must group chronic appendicitis cases under four chief heads. One kind represents an infective lesion, three kinds represent irritative lesions. The infective lesion is one in which we have low grade inflammation within the appendix caused by the presence of fecal matter or round worms for example, or by an extension of some form of colitis including the appendix. This form of chronic appendicitis may give us acute inflammatory outbreaks at any time but the cases on the whole

form a comparatively small proportion of the whole number of cases of chronic appendicitis.

The commonest form of all represents an irritative lesion and not an infective one. I refer to fibroid degeneration of the appendix. This is a normal involution process, the appendix gradually disappearing, leaving finally nothing more than a fibrous string of connective tissue. The nerve filaments remain, however, and these are irritated by the contractive connective tissue. The disturbances consist chiefly in a disarranging of the work of the sympathetic ganglia of the abdominal cavity with various gastro-enteric discomforts rather than dangers.

Still another form of chronic appendicitis, also an irritative lesion, is not quite so common as fibroid degeneration. I refer to the scarred remains of the appendix after acute processes have subsided with destruction of the inner coats of the appendix for the most part. These scarred remains also contain nerve filaments which are irritated chronically. The least common form of chronic appendicitis, but one in which practically all of the operative work is worthless, relates to hypertrophy of the lymphoid coat. It occurs with patients who have a tendency to hypertrophy of lymphoid structures elsewhere in the body and is part and parcel of the cases with sagging colon, loose right kidney and relaxation of peritoneal supports. The appendix attracts attention because the lymphoid coat trying to swell within the tight outer sheath causes more or less transitory pain.

Now as to operative values, removal of the chronic infective lesion is a worth while operation. Removal of the appendix undergoing fibroid degeneration may or may not be worthless. It will relieve whatever part of the case happened to belong to the appendix irritation. These patients are prone to have many other troubles beside. Removal of the scarred appendix which is causing symptoms is usually a worth-while operation. Removal of the lymphoid appendix is almost invariably a worthless operation because the patients are suffering from so many other conditions, the appendix feature playing in very small role. Much disappointment will follow if one intends to accomplish much with the appendix operation alone in two of the kind of chronic appendicitis. The important thing is to make a differential diagnosis.

There are two chief points which help us out. Make deep pressure at the site of the fused ganglion on the right side a couple of inches away from the navel and a trifle below. If the fused ganglion is hypersensitive on deep pressure and none of the other sympathetic lumbar ganglia are sensitive we have first rate evidence that we are dealing with chronic appendicitis. This point is quite a distance from McBurney's point. Tenderness at McBurney's point relates to the appendix itself. Tenderness at this other point near the navel relates to the second and third sympathetic lumbar ganglia known as the fused ganglion. There is another diagnostic point of great value in separating chronic appendicitis from other conditions. It is what I call the "cider barrel sign." It is due to the distension of the ascending colon with gas. If we percuss the left side of the abdomen we bring out a normal resonance suggestive of a cider

barrel in October. If we percuss the right side of the abdomen over the empty distended colon it brings out a note suggestive of the cider barrel in March. These two signs then are of great value in allowing us to distinguish between cases of chronic appendicitis and other abdominal conditions.

Having determined, however, that the patient has chronic appendicitis we must make further examination and decide if the chronic appendicitis is an infective lesion or one of the three irritative lesions. We have to decide in the latter case if the operation will really be worth while or worthless.

Dr. Morris showed several charts illustrating the various points. The topic was discussed by Drs. Dickinson, Rector, Miner and Lange.

MIDDLESEX COUNTY.

Frank C. Johnson, M.D., Reporter.

The regular quarterly meeting of the Middlesex Society was held in the Nurses' Home of the Perth Amboy City Hospital, March 19th, Dr. A. L. Smith, president in the chair. The following committees were appointed by the president for the year:

Program: Drs. Hoffman, Nafey and Fithian. Tuberculosis: Drs. Silk, Brown and Fagan. Professional Welfare: Drs. Weber, Meinzer and Howley.

Special Committee: Drs. Gutmann, Schurman and Naulty.

Legislation: Drs. Lippincott, Urbanski and Shull.

Medical Ethics: Drs. Henry, Hay and Ellis.

Dr. Lippincott, reporting for the Committee on Legislation, outline the program of the State Society Welfare Committee at Trenton; he read a letter he had written and answers received from our U. S. Senators regarding unjust taxation under the Narcotic Drug Act.

A communication from the State Bureau of Venereal Disease Control was read and the matter of having demonstration clinics, was referred to the staff of the Perth Amboy City Hospital.

Dr. Silk outlined in general the plan of the the establishment on land now held by the Recreation Council of Middlesex County for Board of Freeholders near Metuchen, establishing a summer camp there for malnourished children and the use of such organizations as the Boy and Girl Scouts of America.

Dr. Smith called attention to the plan that is now carried out in Pennsylvania by the U. of P. of extension teaching for doctors of medicine in their localities instead of the doctors having to go to the University for post-graduate courses.

Several members present expressed their own desires to attend such local courses and on motion the subject was referred to a committee to consider and act if deemed wise.

The paper of the afternoon was read by Dr. F. S. Jones of the Rockefeller Institute on "The Source and Significance of Streptococci in Market Milk," and he stressed the fact that active infection of the udder of the cow with a type of streptococcus virulent in man is the source of danger.

Dr. John F. Anderson of the Squibb Laboratories gave an excellent discussion of the paper.

MORRIS COUNTY.

D. Marcus A. Curry, Reporter.

The quarterly meeting of the Morris County Medical Society was held on Tuesday evening, March 11th, at the Mansion House, Dover. President Hampton presiding over a good attendance. The meeting brought into fruition the well conceived planning of many months ago by the executive committee and the officers for a reawakening of individual interest professionally as also an improved financial standing.

During the business chapter Treasurer Reed announced with unconcealed satisfaction, that every member was paid up and there were no delinquents; and this happy situation of accounts was no less gratifying to the members in general than to the treasurer.

An invitation to hold the next meeting of the society at Shongum Sanatorium (Morris County Tuberculosis Hospital) was received and accepted with expressions of appreciation.

A Nominating Committee was elected to report at the next meeting their choice of officers for the ensuing year, the personnel of the committee being Drs. Lathrop, Peck and Farrow.

Dr. Sherrill of the Physiatrie Institute at Morristown, presided over by Dr. Frederick M. Allen, was introduced and extended an invitation to the members to attend a function and be entertained at the Institute. Dr. Sherrill spoke on metabolic diseases, stating that what we know about them is more or less in its infancy; that there are metabolic diseases other than diabetes that will bear considerable investigation; that there is on foot now a study which is going to prove of considerable value in several diseases which must be investigated thoroughly and in order to investigate these disease considerable animal research work is necessary; that diabetes itself has been put on a high plane only through animal research work; it was a disease, until a few years ago, not at all well understood; it was only by careful observation and careful animal research work that insulin was developed; that at the Physiatrie Institute we have just recently completed a new animal research laboratory, a brick building costing \$25,000, into which they plan to move within a week; that next Saturday (March 15th) at four o'clock the building would be opened for inspection; that all conveniences for animal research work have been installed; that there would be a number of men present who are interested in metabolic diseases throughout the country and the members were cordially invited to come and join in the inspection and the refreshments; that it was just an informal invitation to an informal opening of a building for animal research work, giving assurance that considerable work of interest would be carried on in this new building.

The unanimous action of the society was to accept the invitation so cordially and interestingly extended by Dr. Sherrill.

The election of new members was a busy chapter of the meeting and resulted in the following additions to the society: Drs. R. Ralston Reed, Jennie Dean Beavers, Anna L. Alaben, Malcolm Smith of Morristown; Drs. Peter S. Hann, Dover; Stephen Campbell, Madison; E. P. Shope, Mendham.

President Hampton announced that successful attempt had been made to interest the members in writing papers instead of having an outside man for this meeting and that there were five papers by local men, the subject being "A Symposium of Pneumonia," the papers read being as follows:

1. "Pathology of Pneumonia," by Dr. Thomas B. Christian, pathologist at the State Hospital at Morris Plains;
2. "Symptomatology and Diagnosis," by Dr. Frederick W. Flagg of Rockaway;
3. "Surgical Aspects," by Dr. William F. Costello of Dover;
4. "Treatment," by Dr. S. C. Haven of Morristown;
5. "Diathermy," by Dr. F. H. Glazebrook of Morristown, also exhibiting and demonstrating a diathermic apparatus.

A paper also was read by Dr. Rubin of Morristown, treating chiefly with "Pneumonitis and Post-Operative Cases."

Discussion of the papers were entered into by Drs. Reed, Lathrop, Larson and others. Former President Lathrop crystallized the general sentiment when he said: "I think this is the most interesting meeting of the Morris County Medical Society I ever attended; and I certainly congratulate the members who have read papers and have made this meeting the very intensely interesting one it has been."

The enthusiastic interest of the members not showing any indications of abatement, President Hampton found it necessary mildly to admonish them that the hour of eleven had arrived and a repast was awaiting, whereupon the gathering adjourned to the dining room and partook of an appetizing supper.

Dr. Julia C. Mutchler, owing to the lateness of the hour, had only brief opportunity to speak on the lack of medical legislation at the recent session and of matters affecting the Welfare Committee and the State Society.

SOMERSET COUNTY.

Dan S. Renner, M. D., Reporter.

The Somerset County Medical Society held a meeting, which was presided over by the new officers, Dr. Philip Embury, president, and Dr. A. A. Lawton, secretary, on February 14, 1924, at the Court House in Summerville. Twelve members were present.

After the regular routine business, Dr. Edgar Ill of 1002 Broad Street, Newark, presented a most instructive and practical paper on carcinoma, its early diagnosis and treatment; the subject was thoroughly discussed, and Dr. Ill was extended a rising vote of thanks.

Local Medical Societies**Bayonne Medical Society.**

M. I. Marshak, M. D., Reporter.

The Bayonne Medical Society held its March meeting on March 17, 1924, at the Elk's Club, Dr. Sid Chayse presiding.

Dr. W. A. Pinkerton read a paper on the Acute Abdomen. The paper was very well received and covered the subject succinctly and to the point. Among the outstanding points were the following: "The topic though a much hashed over one is of a great deal of importance. In no field of medicine does quick, accurate decisions count so much. A few

hours difference may mean the difference between a rapid convalescence and a long drawn out illness, and frequently life itself depends on our decision.

The acute abdominal conditions are roughly speaking, appendicitis, cholecystitis, renal colic, acute indigestion, intestinal obstruction in its various forms, ruptured viscera (most frequently, gastric or duodenal ulcers) pancreatitis and in the female patient, pelvic cellulitis, pus tubes, ruptured ectopic and ovarian cyst with twisted pedicle. History of indigestion, belching, pain either local or general, nausea vomiting, muscular rigidity and tenderness on pressure are signs and symptoms common to all types of acute abdomen. Pain is the most common symptom. Intestinal pain itself is mostly due to distension of the lumen of the gut or to excessive peristalsis, causing tension or drag on the mesentery. The chief guide posts in diagnosis are briefly: Acute indigestion. Favorable response to treatment and no definite local tenderness or rigidity. Appendicitis. History of former attacks; a tense right rectus and tenderness over McBurney's point, the white cell count being a great aid in indicating the progress of the disease.

Cholecystitis. Nausea, vomiting, pain radiating to the right shoulder, jaundice, local tenderness elicited by deep pressure on inspiration is one of the best diagnostic points. Renal Colic. Blood or pus in urine with frequency and pain elicited by blow over affected kidney.

Obstruction. The longer the delay the more intestinal paresis and resulting enter into the case. However it is difficult to differentiate between fecal impaction which will eventually yield to treatment and a real obstruction which requires prompt surgical intervention. When fecal vomiting occurs it is frequently too late to operate. Symptoms of obstruction lasting over 24 hours with beginning distension and especially tinkling sounds on auscultation are indications for operation.

Ruptured gastric or duodenal ulcer. There is a previous history of indigestion. A sudden sharp pain followed by extreme prostration with pinched, anxious expression, with rigid abdomen and sometimes demonstrable pneumo-peritoneum. Acute pancreatitis. The pain in this condition is agonizing in the extreme. Vomiting of a persistent nature is early. There is marked rigidity and according to Holstead a peculiar cyanosis of the abdominal wall is present.

Discussion brought out the facts that the question of when to operate was a difficult one to decide in many cases. Delay in the real acute case is inexcusable. That in cases of marked acute distension operation is imperative early, otherwise paralysis with rupture of the intestinal wall and generalized peritonitis ensue. If in acute obstruction the symptoms continue after washing out the stomach and bowels, operation is necessary at once. That on operation only the essential work be done because there is a tendency to do too much on these cases.

Drs. Sexsmith, Forman, Harvey, Larkey, Brooke and Pinkerton discussed the paper.

Clinical Society of Beth Israel Hospital.

The regular monthly meeting was held February 6th, 1924, Dr. Greenfield, the president, in the chair. Dr. Aaron E. Parsonnet presented a paper giving report of eleven cases of diabetes mellitus treated with Insulin, which was discussed by Dr. Theodore Teimer, Dr. Levy and others.

This paper and discussion will appear in next month's Journal.

Other Medical Organizations

PHYSIATRIC INSTITUTE, MORRISTOWN.

Animal Research Laboratory Opening.

Dr. Frederick M. Allen, Director.

Marcus A. Curry, Reporter, Morris County.

An event of universal and profound interest to the medical profession and of monumental aspect to those members of peculiar intensity who ever are probing and advancing into the realms of research for new discoveries, and benefactions to humanity itself took place on Saturday afternoon and evening, March 15, 1924, at the Physiatic Institute, Morristown, New Jersey. The occasion was the dedicatory exercises and inspection of the new Animal Research Laboratory now established in a not elaborate but fully adequate brick building at a cost of \$25,000. Dr. Allen stressed the point that heretofore thousands upon thousands of dollars had been put into buildings for experimental work and after the building was completed there were no funds for proper equipment, maintenance and the necessary laboratory force; that he had taken the opposite view in having a good serviceable fire-proof building, constructed as economically as possible, not elaborate but adequate, and put the money in equipment and scientific personnel instead of the building itself.

Medical men from near and far, among which were many of the Morris County Medical Society, were present and were afforded every attention and consideration to enable a thorough inspection and appreciation of what is being done not only with respect to diabetes but in other metabolic diseases, such as high blood pressure, kidney affections, etc. Along these lines a great deal of research work is being done at the Institute, although the time has not as yet arrived to make announcements of findings, nor will this be opportune until the findings have been proven through animal experimentation. It is conceded that what is known of metabolic diseases is more or less in its infancy; that there are metabolic diseases other than diabetes that will bear considerable investigation; and the establishment of the Animal Research Laboratory is a definite and signal step at the Physiatic Institute in the progress of a study which is going to prove of considerable value in several diseases which must be investigated thoroughly. It is well known that the treatment of diabetes itself has been put on its present high plane only through animal research work and it was only by careful observation and animal research work that insulin was developed; so important anticipations are held for the work at the Animal Research Laboratory which now is a reality at the Physiatic Institute and a credit to the State.

DO NOT FAIL TO ATTEND YOUR COUNTY SOCIETY'S MEETINGS

Luncheon was served to all who attended the dedication.

By a happy stroke of synchronism the day of the dedication of the Animal Research Laboratory was also the forty-fifth anniversary of Dr. Allen's natal day and as an observance of this occasion there was a dinner at the Institute in the evening which was grasped as an opportunity by the many outstanding medical men present to bestow upon Dr. Allen not only congratulations on his attained two score and five but also many much merited encomiums for his achievements in his professional progress.

Among the speakers at the "Birthday Dinner" were Dr. David F. Weeks, superintendent of the New Jersey State Village for Epileptics at Skillman, who spoke for the County Societies of Somerset and Mercer and Dr. Allen's co-operation in the study of metabolic diseases. Dr. Sherrill of Dr. Allen's staff at the Institute spoke of the work that Dr. Allen had done but was too modest to mention.

Dr. David C. English, editor of the Journal, congratulated Dr. Allen upon having achieved so much in such a short span of life as forty-five years; and mentioned his own recent eighty-second anniversary when he was showered with congratulatory messages on the work he is carrying on as editor of the Journal; and advancing the happy thought that Dr. Allen is a comparatively young man and there was no reason why Dr. Allen should not live and carry on his wonderful research work until he too at least reached the four score and two milestone of life.

Dr. Marcus A. Curry, superintendent of the New Jersey State Hospital at Morris Plains, spoke for the Morris County Society and in recognition of Dr. Allen's ever willing co-operation with the State institutions in establishing clinics and trying to work out their problems and of Dr. Allen's readiness at all times to co-operate with the physicians in any part of the country and to assist them in their problems of metabolic diseases.

Other speakers sounding the harmonious note of praise of Dr. Allen and his work were: Dr. Wells P. Eagleton of Newark, president of the State Medical Society; Dr. Graham Lusk, Professor of Physiology, Cornell Medical School; Dr. E. F. DuBois, Associate Professor of Medicine, Cornell Medical School and affiliated with Russell Sage Institute of Pathology, New York; Dr. Clifford Mills of Morristown; Dr. Waldren E. Munns of the Cardio-Vascular Department, Post-Graduate Hospital, New York, and other.

On Dr. Allen's staff from foreign countries are: Drs. Mark, Modern, Copp, Lundin, Zimmerman and Barkley. Several of these men congratulated Dr. Allen on the work he is doing and some of these foreign men stated that the reason they wanted to come over and join the staff was that Dr. Allen is known abroad in England, Germany, Switzerland and other countries as one of the most advanced research workers and they wished to be associated with him in his work.

A wonderful work is being carried on and the results should redound to the everlasting credit of Dr. Allen and his Institute and bring honor to the State of New Jersey.

The Editor is glad to have received from another the following additional outline of the remarks of Dr. F. M. Allen in responding to the complimentary after-dinner speech by distinguished guests:

The Physiatrie Institute was established in Morristown in June, 1920. Its organization and development have been governed chiefly by conditions of necessity.

On leaving military service in 1919, I was unable to obtain any academic position that would support my research. As my efforts in this direction continued unavailing during a year of medical practice in New York, and as metabolic research is expensive and practically limited to a few well endowed and controlled institutions, I was forced to conclude that the only hope lay in developing a new organization for this purpose. Only absolute necessity could have driven me to risk everything on such a gamble, for I was not ignorant of the expense, labor and danger incurred.

The conception of the Institute is essentially that of bringing patients and research workers closer together. Patients need research, and the progress in diabetes within the past few years illustrate the possibilities in this field. It seems an advantage for patients to receive treatment from those who are devoting themselves to such investigation, and an advantage for the investigators to have this clinical opportunity. Also, it should be emphasized that nearly all patients, including the wealthier ones who would scorn charity, have actually been the objects of charity in regard to the scientific investigation of their disease, for such investigation has been paid for only by the philanthropy of a few specially rich individuals. I have ventured to assume the research is worth its cost; that an institution which carries on research can build up a better staff and give better treatment than one which does not; that the charges to patients must be higher in order to support research but the practical benefits to them are worth the difference. Some patients have contributed further by gifts or loans in aid of the Institute, and though no large donations have been received, this plan still seems to hold great possibilities. The aggregate wealth of the patients with diabetes, nephritis, hypertension, etc., is vastly greater than that of any single individual, and by co-operation such patients can support the investigation of their own problems on a scale never before possible. Both humanitarian motives and intelligent selfishness should prompt them to such action.

The actual outcome thus far is that the Institute has at least survive and grown for nearly four years. Though we have spent much money in Morristown, we have had no support from the local public, and there is not a cent of Morristown money in the Institute. We have also had no contributions from any of the great endowment funds of the country. The understanding and support on the part of the medical profession have been particularly gratifying. The attitude of physicians and their societies, in Morristown and throughout New Jersey, has been extremely cordial from the outset. The referring of patients here by physicians in this State, in New York and in the entire country is the one factor which has enabled the Institute to live. There have been

and still are hard financial struggles, but the support is increasing and the Institute has become stronger each year. No charity patients who seemed honest and worthy has been rejected in these four years. The Journal of Metabolic Research has been published at the necessary loss. An increasing staff and volume of research have been supported. And while at first the equipment of one small laboratory was a burden, and later animal experiments were performed under difficulties in the old dairy at one end of the barn, we have now reached the stage of completion of a new fireproof building devoted entirely to animal experimentation. I wish to express gratitude to Dr. Lusk and Dr. DuBois as representatives of scientific metabolic research, and to Dr. Eagleton, English, Weeks, Currie and other representatives of the New Jersey medical profession, for their kindness in attending the formal opening of this new laboratory and for their expressions of confidence and encouragement with regard to the Institute.

Anyone coming merely to see this new building, and acquainted with the palatial structures which some of the highly endowed institutions can boast, may be disappointed, but the difference in appearance means also a difference in policy. Millions of dollars are being expended on medical science in this country, and yet research work is poorly supported and willing workers find opportunities scarce. The money is spent so largely on building's notion of ideal research conditions that little is left for carrying on the actual investigation. Equipment is necessary, but men are more important. A good investigator can work under almost any conditions and generally with very simple apparatus. We have therefore built here practically a two-story fireproof shed, and of the plainest and cheapest construction possible. We are equipping it with everything needed for work and with nothing for display. We are reserving most of the money for men and for the current expenses of research. We therefore have the largest staff in proportion to the cost of the building in which they work, and the largest expenditure for direct research operations in proportion to overhead and other costs, of any institution with which I am acquainted. According to our experience, the control of a medical research institution by medical and research men, instead of by laymen, is also a factor which makes for efficiency.

More important than equipment or number of staff are their character and spirit. I know that these young men had excellent training before coming here, and I have confidence in their ability, but I am particularly proud of the spirit which they have shown toward their work. They voluntarily put in long hours without urging. They do not shrink from hard routine or from dirty drudgery. Research that accomplishes anything inevitably involves deadly routine, hard work and often dirty work. The investigator who shuns hardship, who dabbles in a laboratory for a few hours a day, and who tattles pleasure in posing before the public as a scientist, is no longer a scientist. There is too much of this dabbling and posing everywhere today. There is too much loafing by men who have turned endowed research positions into sinecures. The literature is too crowded with papers

which are published for the mere glory of publication, and there are too few real contributions in the sense of valuable ideas faithfully worked out to increase knowledge. I believe that these young doctors who have enthusiasm even in cleaning dog cages will make real contributions.

Though we are grateful for the praise and congratulations voiced by the speakers on this occasion, this is really no time for bouquets. We have as yet only a small struggling institution. It has produced no important discovery. Its work is only beginning, and its success can only be judged in the future. But granting that the financial problem can be solved, I have faith that the Institute will fulfill the hopes of its friends.

Philadelphia County Medical Society.

At the annual meeting of this society, held Jan. 9, 1924, Dr. David Riesman, in his address as the retiring president, said:

State Legislature.—In the early part of the year 1923 the Pennsylvania State Legislature met at Harrisburg. Many bills of direct interest and concern to the medical profession were introduced and considered. Representing our own membership as well as the State Medical Society, Dr. George A. Knowles handled a situation often extremely difficult and delicate to the best interests of the profession and of the public. The committee of which he is the head, should at all times have the loyal support of medical men and women of the State.

In this connection I want to refer to the very original and interesting plan adopted by Governor Smith of New York when he went into office. As you probably know, he called to his side medical men holding leading official positions in the State of New York, and appointed them an Advisory Committee on health matters. The character of the appointees was a guarantee that the questions referred to them would be considered in a spirit of fairness. The result was that no bill inimical to the public welfare insofar as it touches health has since then been put on the statute books of the State of New York.

It is an admirable plan which might well be put into practice in Pennsylvania. Its adoption by the Governor would do away with the unpleasant duty of maintaining a sort of medical lobby in the Legislature, a political necessity under present conditions if we want to conserve the interests of the public and want to protect medical and scientific progress.

Medical Cults.—During the last three decades this country has witnessed the rise of certain medical cults that appeal vociferously to the public for support. In many communities this appeal has been answered not only by popular moral support but by legal sanction, contrary to the best interests of the public welfare and of scientific progress. The medical profession—justly proud of its great traditions and conscious of its hard acquired training—has looked with contempt, if not with resentment, upon these loud voiced prophets of a new medical era. In the case of some of these cults, as for example that which is stretching its tentacles from San Francisco across the land, the feeling of con-

tempt is justified. But there are some special forms of practice that have a little to their credit. After all there are "sermons in stones and good in everything."

The time has come, in my judgment, when it is the duty of the regular medical profession to investigate dispassionately the merits and demerits of some of the practices that I have in mind. Medicine has at all times been willing to take from every source the good there is in it. The Philadelphia County Medical Society possesses all the necessary machinery to make a thorough and impartial investigation.

(We call attention to the fact that Governor Silzer of our State has appointed an Advisory Council of medical men on health matters, after consultation with the Welfare Committee of our State Society. We believe that in New Jersey no legislative bill believed by our council to be "inimical to the public welfare insofar as it touches health" should be put on the statute books of our State.—Editor.)

Academy of Medicine Anniversary.

Alfred Stahl, M.D., Reporter.

The anniversary meeting of the Academy of Medicine of Northern New Jersey was held on the Academy Auditorium on March 19th. Dr. Henry J. F. Wallhauser, the president of the Academy, briefly reviewed the very satisfactory work of the Academy of the past year, the well attended meetings and the many excellent and instructive papers presented. Dr. Wallhauser in behalf of the Academy, accepted with deep feeling and gratitude the wonderful gift to the Academy of a large number of rare and very old books by Dr. Edward J. Ill. The inestimable value of these gifts will be appreciated when it is known that among this collection there is one book of which there are but two other copies in existence, one in Washington and one in Europe.

At this meeting Dr. Wells P. Eagleton, president of the Medical Society of New Jersey reviewed the work of the Welfare Committee during the past year in legislative matters. The absolute necessity of unified and organized effort of the medical profession in its relation to legislation and the public was forcibly stressed.

Dr. Henry H. Rusby, Dean of the College of Pharmacy of the City of New York, delivered the Anniversary Discourse: Title, "The Caapi Drinkers of Columbia." The very interesting subject was illustrated by moving pictures.

The Surgical Section of the Academy of Medicine of Northern New Jersey met on January 22, 1924. Dr. Richard H. Dieffenbach in the chair.

The chair appointed a nominating committee for officers for the ensuing year.

After the usual order of business a most interesting paper was read by Dr. Max Danzis on "The Present Status of Gall-Bladder Surgery" with a report of 140 cases.

Dr. Danzis discussed the subject of Cholecystostomy vs. Cholecystectomy, reviewing the literature and giving us the opinion of all great surgeons on this great question. He strongly emphasized the danger of injury to the bile-ducts in cholecystectomy and be-

lieves the average surgeon should perform cholecystostomy. He pointed out to us that cholecystectomy gives us a higher percentage of cures but cholecystostomy a lower mortality rate. The paper was most complete, analyzing his series of 140 cases, giving the percentage of deaths, unimproved, improved and cured.

Discussion was opened by Dr. E. J. Ill, followed by Drs. Geo. A. Rogers, Maurice Asher Hagerty, Haussling, Polefski and Carman.

Brooklyn's Campaign Against Quacks.—Dr.

J. E. Golding of the King's County Medical Association says: "For months this organization has been collecting evidence through questionnaires and interviews with patients who have fled in distress from the alleged quacks, and all this material was put in the hands of the District Attorney." Dr. Golding believes that his organization has succeeded in getting the name of virtually every quack in Kings County. District Attorney Dodd says: "I shall not be satisfied with fines in these cases. The District Attorney's office will do its utmost to see that every man found guilty receives a prison sentence."

"The raids will continue until there is not an unqualified man practicing medicine in the entire county. We have been offered all the help possible from Commissioner Enright. Special service men and detectives are working with us and the list of suspected quacks is going to be rounded upon and prosecuted."

What the Regular Profession of Medicine Has Done.

Voltaire's gibe that "Doctors were men who crammed medicine, about which they knew little, into bodies about which they knew less, to cure diseases about which they knew nothing," has received the attention of Dr. Frank Crane, who needs no introduction. He proves to the contrary. In brief, he says that regular physicians have done, and are doing more for the human race than all the cults, fads, quacks and pathies put together; which is true, and shows how surgery, sanitation and education has lowered the death rate from 19.6 in 1908 to 13.1 in 1920.—Buffalo Sanitary Bulletin.

Connecticut Licenses Revoked.—Twenty-six additional "physicians" have had their licenses revoked in connection with the grand jury investigation. They were diploma mills graduates.

Our Society stands, and I hope always will stand, for democracy in the medical profession. It demands nothing of anyone desiring to become a member except that he shall be a doctor and shall have a good character. That is not a great deal compared with the requirements of some other organizations, but is not the combination of doctorhood and unblemished character something fine and noble? Proud as I am of my profession, I cannot conceive of a better product of man's evolution from the Piltown or Neanderthal creature to our time than the upright physician.—Dr. Riesman, Phil. County Society.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

14 SOUTH DAY STREET, ORANGE, N. J.
Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

CHAS. D. BENNETT, M. D., Chm., 177 Clinton Avenue, Newark.
JOHN B. MORRISON, 97 Halsey St., Newark.
EDWARD J. ILL, M. D., 1002 Broad St., Newark.
DAVID C. ENGLISH, M. D., Editor, 65 Paterson Street, New Brunswick.

EDITOR:

DAVID C. ENGLISH, M.D.,
P. O. Box 83, New Brunswick

ASSOCIATE EDITORS:

CHRISTOPHER C. BELING, M.D., Newark
HENRY B. COSTILL, M.D., Trenton
JAMES HUNTER, JR., M.D., Westville
HARRISON S. MARTLAND, M.D., Newark
FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

ONE HUNDRED AND FIFTY-EIGHTH

Annual Meeting of the

Medical Society of New Jersey

will be held in

HADDON HALL, ATLANTIC CITY

June 5, 6, 7, 1924.

The Editor has received the following letter from Dr. W. B. Olmstead, Secretary of the Committee on Program and Arrangements:

Dear Dr. English: March 18, 1924.

Answering yours of the 15th inst., we do indeed want some "publicity" in the April Journal and each number thereafter until after the meeting. We thank you for bringing the matter to our attention.

The Annual Meeting will be held at Haddon Hall, Atlantic City, New Jersey, on June 5, 6, 7, 1924. Everything points to the largest attended and most successful meeting we have ever held. Dr. Eagleton,

Dr. Kellar, Chairman of the Scientific Committee, and everyone else has co-operated with our committee so sincerely as to leave no doubt as to the outcome of the meeting. We have secured Dr. Beardsley and Dr. Bloodgood to present the Orations. Social events will feature the evening meetings, except that Dr. Eagleton will present the President's Address, and a report of the Welfare Committee during the formal dance and buffet supper on the second evening (June 6th).

A number of hotel reservations have already been made, so it behooves all to reserve early and avail themselves of the special reduced hotel rates. * * * *

W. D. OLMSTEAD,

Sec'y of Committee on Program and Arrangements.

ARE OUR LEGISLATORS MERE POLITICIANS?

We recognize the fact that there are two classes of politicians. One seeks to serve the public to the best of his ability for its highest welfare, and we honor him; the other seeks his own pecuniary and other selfish interests in exploiting the public and he will not hesitate to favor the bootlegger, the gambler or other lawbreakers if by so doing he can gain more power and money. Some even favor wine and beer laws in order to get the saloon back where most of the infamous work of buying and selling votes and otherwise corrupting voters was done.

The practice of medicine is not a *business* but a profession that seeks the public's welfare in protecting the lives and health of the people. But we believe Dr. Eagleton, the chairman of our Welfare Committee, is right when he says: "*We must get in politics*" in order to get better legislators. During the past winter our Society, through its Welfare Committee, has sought to have enacted a few laws, which were solely for the public's welfare. None of them were for the welfare of the members of our profession, in fact they were detrimental to our pecuniary interests, but they did not suit the politicians in the Legislature or their friends—the false cults that are *in business to make money*.

What shall we do? We reply, by endorsing and acting upon the suggestion in the editorial we give below, from the Atlantic Medical Journal, "*SAY IT WITH VOTES.*" Let us get busy helping the people to select honorable legislators next fall, men who have the interests of the people

at heart. We should have at least two able physicians in the Senate and three or four in the Assembly. We are exceedingly sorry to have Dr. Barber leave the Senate to which he had just been re-elected for a three years' term. Let us elect men next fall, who will be unselfish enough to serve the public honestly and faithfully. We need politicians of the first class we have spoken of and we are of the opinion that as far as the outcome of the legislation of the past winter is concerned, there has not been one who has more nearly approached the ideal than our worthy Governor.

The following are the results of our legislative efforts. Bills passed: Senate Bill 77, compelling colleges and schools established in New Jersey to teach the healing art in any of its branches, to apply to the State Board of Medical Examiners for license to act; they must possess the equipment and facilities of Class A medical schools. Also Assembly Bill 169, guarding against poisoning in using lye. All legislation we opposed was defeated. Though Assembly Bill 289, known as the Chiropractic Bill passed, Governor Silzer vetoed it and it failed to pass over his veto, lacking three votes.

SAY IT WITH VOTES.

From Atlantic Med. Journal.

Some enterprising florist coined the phrase "Say it with flowers." That saying has been taken up throughout the country until now it is one of the best known advertising slogans extant.

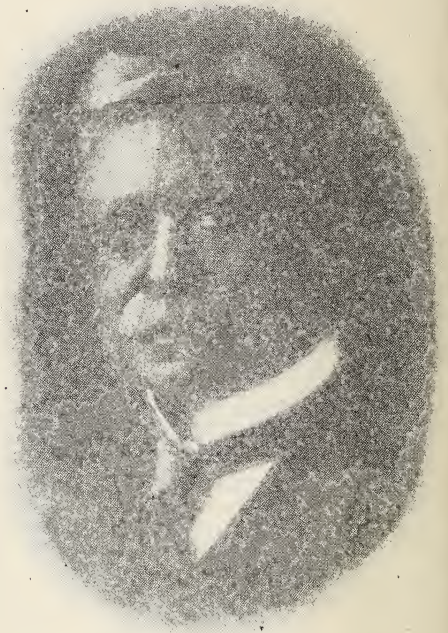
What more attractive wording could be suggested? Saying it with flowers offers a medium for the expression of almost every sentiment—esteem, affection, reverence, sorrow. Not only has this slogan profited the florist financially, but it has increased the popular use of some of nature's choicest products, and has enhanced the esteem in which he is held as a purveyor of these products.

The medical profession has a similar condition to meet. We want to increase our prestige with the members of the Legislature. Let us, then, adopt a similar slogan: "SAY IT WITH VOTES."

The time will soon be here when you can express your appreciation to those who will give us a square deal in the Assembly, as well as administer—in some instances—an effective rebuke to those who have proved false and have not been true to their word, to those who seek the office of senator or representative but have no regard for the

health and physical welfare of the people. To all these you should *say it with votes*.

Don't forget that unless it is said with votes at the spring primaries and the fall elections, we may need the flowers to express our regrets. Don't be a "dead one."



Enoch Hollingshead, M.D.

Dr. Hollingshead was one of the most faithful members of our State Society from his election in 1869 until his death in February of this year. He was elected Third Vice-President in 1910; his vice-presidential address in 1911 was on "The Progressive Changes in Forty Years"; elected President in 1913 his address at the 1914 Annual Meeting was on "Medical Problems." Both addresses were exceedingly interesting and instructive. Since then he served as a Trustee. He was very rarely absent from an Annual Meeting and faithfully performed the many duties assigned to him. He will be greatly missed.

PHYSIATRIC INSTITUTE.

We call special attention to the articles of Dr. M. A. Curry and others on page—on the "Animal Research Laboratory Opening" of the Physiatic Institute, Morristown, last month. It was an occasion of great interest not only on account of the laboratory opening, but also because it was a testimonial to Dr. Allen in the "Birthday Dinner" given him. It was eminently proper that this recognition was given of the great

work Dr. Allen and his associates have done and of the splendid results that have followed that work, carried on in a devoted self-denying spirit!

This institute is worthy not only of the unqualified endorsement of the medical profession, but also of the liberal financial support of the public. \$50,000 or more could be wisely expended this year in more adequate equipment of the institute that would enable its devoted staff to do the greater work that it is eminently qualified to do.

The State Society's Official List is sent with this issue of our Journal which went to press earlier than usual. This has compelled us to defer insertion of some matter, received at a late date, until next month. A list of new members and reinstated members who paid their dues after the Official List went to press, will be given in next month's Journal.

Learn to say "I don't know." But learn so much that you won't often have to—Forbes Magazine.

Too Many County Societies Sleeping.

Too many of our county societies are sleeping, arousing just enough at necessary intervals to keep their names on the books. The council is held responsible for them under the constitution and by-laws of the State Association. It is hard to believe that the councils in some instances realize their responsibility. Perfunctory reports made at some annual meetings indicate that they do not. Councilors' reports made up from letters sent out the week before the annual meeting of the State association are not reports—they are evasions. Councilors are supposed to visit—actually visit—the societies in their respective districts at least once each year. How many do so? Councilors are supposed to "inquire into the condition of the profession," to "organize component societies where none exist," to be "peace makers and censors," to "improve the zeal" of county societies. These things cannot be done by writing a few letters ten days before the annual meeting and then turning in what purports to be a report, which, formulated in that manner, nearly always makes it appear that everybody is happy and that medical organization is 100 per cent. efficient, when, as a matter of fact, the formality of a funeral is about all that is necessary, in some instances, to carry out the very distinct indications as presented by the situation that really exists. Within thirty days, the organization of five independent local medical societies has been reported in territory already occupied by county medical societies supposed to be alive and going. What's the matter? Why are the societies already in existence not meeting the needs of their members? Why do they find it necessary or desirable to go off and form new and independ-

ent societies? Those things are for the councilors in the respective districts to find out. And it is their duty to try to remedy any condition in the county societies concerned that is responsible for these undesirable situations.

—A. M. A. Bulletin, Dec., 1923.

Welfare Committee Meetings.

A special meeting was held in the Essex Club, Newark, on February 17, 1924. Those present were: Drs. W. P. Eagleton, chairman; J. B. Morrison, F. W. Pinneo, James Hunter, H. B. Costill, W. G. Schaufler, Andrew McBride, J. C. McCoy, A. H. Lippincott, G. T. Banker, D. C. English, A. L. Smith, L. Ely, F. J. Quigley, W. M. Darnall, J. B. Morrow, Henry Spence, Julius Levy. Dr. H. W. Haight, of the State Society Health Education Committee, was also present.

Dr. Eagleton announced that the first matter to be considered was the attitude of the Welfare Committee in regard to Assembly Bill 292, providing for a health director in the State Department of Education, and which was sponsored by Dr. Haight, and in which the Medical Society's name as endorsing it, had been used without authorization. Dr. Eagleton outlined the previous actions of the committee with reference to the bill.

There was a general discussion of the subject, including an explanation by Dr. Haight of his course in connection with the bill. The consensus of opinion was one of opposition to the bill at the present time. On motion by Dr. Schaufler, it was unanimously declared to be the wish of the Welfare Committee, acting in the name of the Medical Society of New Jersey, that Assembly Bill 292, providing for a health director in the State Department of Education, be withdrawn from the Assembly. Dr. Haight announced that he would comply with the request of the committee and would have the bill withdrawn from the Assembly to-morrow night.

On motion by Dr. Costill, it was directed that in the event that Assembly Bill No. 292 was not withdrawn from the Assembly, that a communication be sent to every Legislator, Senators and Assemblymen, informing them that the Welfare Committee, the Medical Society of New Jersey and acting for the State Society, is opposed to the passage of the bill.

Dr. Quigley presented a draft of a bill dealing with the use of the title "Dr." as prepared by Mr. William Whiteside, counsel for the Medical Society of New York, and read the bill. Dr. Pinneo presented a draft of a bill on the same subject, prepared by Mr. Stryker, and read the bill.

On motion by Dr. Morrison, seconded by Dr. Quigley, the committee voted to accept the bill presented by Dr. Quigley with some minor changes, and offer it as a substitute for Senate Bill No. 159, dealing with the use of the title "Dr."

On motion by Dr. Quigley, seconded by Dr. Pinneo, it was decided that the Welfare Committee now make preparations to have drafted a bill which would revise the entire Medical Practice Act, and to have a draft of the bill ready for discussions by the Welfare Committee, about May 1, that it may be presented to the State Medical Society for consideration at the annual convention in June.

February 25th, 1924.

A meeting of the Welfare Committee was held in the State House, Trenton, on February 25, 1924.

Present were: W^r. Wells P. Eagleton, Dr. James Hunter Jr., Dr. W. G. Schaufler, Dr. Thomas Dedrick, Dr. Henry B. Costill, Dr. D. C. English, Dr. Frank W. Pinneo, Dr. Frederick Quigley, Dr. Alexander MacAlister. A general discussion of legislative matters was had. On motion by Dr. Costill, it was decided to call for a demonstration of physicians at a hearing on the Committee Substitute Bill for Senate 159, to be held at the Senate Chamber, State House, Trenton, on Monday afternoon, March 3, 1924, at 4 o'clock.

March 2, 1924.

A meeting of the Welfare Committee was held at the Essex Club, Newark, on March 2, 1924. Present were: Dr. Wells P. Eagleton, chairman; Dr. Frank W. Pinneo, Dr. Frederick J. Quigley, Dr. George T. Banker, Dr. T. B. Morrison, Dr. L. Donohoe, Dr. Thomas Dedrick.

Dr. Eagleton announced speakers for the hearing at Trenton on Monday on Committee Substitute for Senate Bill 159 as himself, Dr. Pinneo and Dr. Quigley.

On motion by Dr. Dedrick, a resolution was passed suggesting to the State Medical Society that provisions be made for the appointment by each County Medical Society of a Welfare Committee, to handle legislative matters for the County Society.

On motion a telegram of congratulation was sent to Dr. D. C. English, of New Brunswick, in the name of the State Medical Society and the Welfare Committee, on the occasion of the celebration of his eighty-second birthday anniversary.

The Committee Substitute for Senate Bill 159, which would limit the use of the title "Dr." was read by the committee and some changes made in it.

Certified Milk.

We have received the following from Dr. Curry, reporter of Morris County Society, for publication.

We commend this milk not only to the physicians of Morristown but to the members of the profession throughout the State.—Editor. Dr. Marcus J. Curry.

Dear Doctor:

It is the hope of the Medical Milk Commission of Essex County, New Jersey, to make certified milk available in all the towns of this State and the Wood Brook Farms Dairy of Metuchen, New Jersey, have made arrangements to distribute their certified milk in Morristown, N. J., through the Hipson Dairy Company.

Certified milk is a raw, natural milk produced under contract supervision of methods to insure standards of quality, purity and safety. Certified milk is milk produced under the supervision of physicians for physicians. Every good medical authority admits that such a grade of milk is a nutritional and clinical necessity. We are very earnestly anxious, of course, that it should meet with the professional support that will justify the Wood Brook Farms in maintaining Morristown deliveries; to this end we are bringing the mat-

ter to the attention of the profession in Morris County towns by personal letter. This, however, is necessarily slow and it suggested itself to some of us that a mention of the fact in your monthly report of affairs in Morristown to the State Journal, might bring it more effectively to the attention of the physicians in Morristown and vicinity, than in any other way. The Commission would be very glad indeed to have your friendly co-operation to that end.

This Commission feels that the Wood Brook Farms certified milk fulfills the high standard set or certified milk and is glad of the chance to recommend it to the medical profession of Morristown for use in infant feeding and for invalids and to the general public where a high grade of milk is desired, as in the diet of anaemic and growing children.

Cordially yours,

Floyd McEwen, Secretary.

Hospitals; Sanatorium.

Christ Hospital, Jersey City.—A building is planned for this hospital to cost from three to five hundred thousand dollars.

Orange Memorial Hospital.—The 50th annual report for 1923, shows 729 more patients admitted than in 1922. Total number during the year admitted: Private, 1,326; semi-private, 1,026; ward, 2,039. Total, 4,391. Number of births, 726; deaths, 198; operations, 2,128. Out-patient Department: New cases, 3,465; revisits, 9,480. Accident Room Cases, 1,732.

Overlook Hospital, Summit.—During the last year the debt of \$19,000 on Overlook Hospital has been paid off, according to the annual reports of the officers. This was made possible by 4,908 contributors, who gave sums ranging from ten cents to \$250. Subscriptions were received from persons living as far west as Bedminster and as far east as Maplewood. A gift of \$10,000 was made by Stewart Hartshorn of Short Hills to endow a bed in memory of Mrs. Hartshorn. The hospital administered to 1,462 patients. One hundred and sixty-seven babies were born and 693 operations were performed. Eleven hundred and forty-five patients were Americans.

American Hospital in London.—Americans in London may have medical treatment and surgery by American physicians. The provisional committee of the Hospital in London has opened temporary headquarters in London, where it is ready to care for American citizens, visitors or residents of London. Although the hospital has only been opened a few days, several influenza cases have been taken in and the private room facilities are to be extended for the tourist season.

Essex Sanatorium, Verona.—Need of extra beds at the Sanatorium was stressed by physicians of the advisory and consulting staff of the institution at a meeting of the freeholders' committee there. Dr. I. Edward Gluckman, Dr. Carl H. Ill and Dr. Byron M. Harman, the

latter superintendent, explained the pressure being exerted for admitting women patients especially.

Dr. Harman said that New Jersey was one of the five states in the United States in which tuberculosis was increasing, although records showed a big drop in cases in Essex County. Dr. Gluckman explained the advance in the disease is found in rural sections which lack hospital facilities. The State is now 1,700 beds behind the demand, while in New York there are numerous empty beds. Dr. Harman's report shows 217 patients in Verona March 1, of whom 133 were males and eighty-four females. Thanks were expressed to Soho Hospital for taking fifteen cases, which relieved the pressure due to an extended waiting list. There are forty-one names on the waiting list, of whom twenty-eight are females.

Marriage.

CORWIN-RICHMAN.—In Newark, N. J., March 8th, 1924, Dr. Theodore W. Corwin to Mrs. Gertrude C. Richman, both of Newark.

Deaths.

DORON.—In Camden, N. J., February 18th, Dr. John G. Doron, of cerebral hemorrhage, aged 63 years.

Dr. Doron graduated from the Univ. of Penn. Medical School in 1887.

BLEYLE.—In Newark, N. J., February 11th, Dr. Herman Conrad Bleyle, aged 78 years.

Dr. Bleyle graduated from the Bellevue Hospital Medical College in 1863. He was a Civil War veteran, was a member of the Essex County and State Medical Societies and of the A. M. A.

BRODERICK.—In Jersey City, N. J., Mar. 25, Dr. John J. Broderick, aged 55 years.

Dr. Broderick graduated from St. Peter's High School and St. Francis Xavier's College, and in 1890 graduated from the Bellevue, N. Y., Medical College. For many years, had been engaged in medical work on the Jersey City Police Department. In December he suffered several attacks of the heart but believed that he had been cured at the City Hospital.

JOY.—In the Atlantic City Hospital on February 28th, 1924, Dr. Percy A. Joy, aged 33 years.

Dr. Joy was a son of Dr. J. Addison Joy of Atlantic City. He was born in that city. He attended the Atlantic City High School being graduated in 1912. From there he went to Amherst and later to the Jefferson Medical College from where he was graduated with honors in 1915. While serving the probationary period following his graduation, the United States declared war on Germany. Dr. Joy at once enlisted with Battery D, under the command of Captain W. Frank Sooy. When the company was taken over by the Federal government he was commissioned in the medical corps and given the rank of first lieutenant, being attached to 112th Field Artillery.

He saw active service in France and when the command returned to this country was mustered out. He returned to Atlantic City and opened an office at 1912 Pacific Avenue. He became closely associated with the local hospital where he was looked upon as one of the most promising younger physicians of the city. He contracted a severe cold on Saturday, February 23, and although quite sick he insisted upon attending to his patients on Sunday and Monday. He brushed aside all suggestions that he think of his own health first, and it was not until Tuesday evening that he entered the hospital, when pneumonia developed and soon caused death.

He was a member of his County Medical Society, the State Society and the A. M. A. He was also an ardent member of the American Legion and an officer in Atlantic City Post No. 2, who accompanied the body to the grave.

ROGERS.—In Newark, N. J., on January 27th, suddenly, Dr. George A. Rogers, aged 53 years.

Dr. Rogers graduated from the College of Physicians and Surgeons, N. Y. City, in 1892. He was a member of the Essex County Society, the State Society and the A. M. A., also a member of the American Association of Anesthetists, and the staff of the Hospital for Women and Children, and the Beth Israel Hospital.

ROMINE.—At the University of Penn. School of Medicine, February 7th, Dr. George L. Romine, of Lambertville, N. J., aged 71 years.

Dr. Romine graduated from the University of Penn. School of Medicine in 1880. He was a member of the Hunterdon County and State Medical Societies and the A. M. A.

SMITH.—In Montclair, N. J., January 31, Dr. Anna Louisa Smith, aged 73 years.

She graduated from the Woman's Medical College in 1886; was a member of the Essex County and the State Medical societies.

We are obliged to defer insertion because of late arrival of memorial items concerning Dr. Hollingshead and Reading until next month.

We are sorry to add that the marriage and death notices above were not received from county society officers but were culled from newspapers. The Editor should be notified promptly of the deaths of members.

MEDICAL EXAMINING BOARDS' REPORTS

	Exam.	Passed.	Failed.
Delaware, June . . .	1	1	0
Hawaii, October . . .	5	5	0
Illinois, January . . .	46	18	28
Kentucky, June	35	34	1
Massachusetts, Nov..	49	31	18
Michigan, June	51	51	0

Ohio, reciprocity, 20 were licensed.

The National Board of Medical Examiners examined in Sept., 1922, 91 candidates of whom 73 passed and 18 failed.

Federation of State Medical Boards.—At the annual business meeting of the Federation of

State Medical Boards, held in Chicago, March 4, the following officers were elected: President, Dr. David A. Strickler, Denver; president-elect, Dr. Thomas McDavitt, St. Paul; vice-president, Dr. H. M. Platter, Columbus, Ohio; secretary-treasurer, Dr. Walter L. Bierring, Des Moines, Iowa; member executive committee, Dr. Alexander MacAlister, Camden, N. J.

Public Health Items.

Health Officers' Meeting.—At the annual meeting of the New Jersey Health Officers' Association in Trenton, February 15, Joseph C. Saile, Bloomfield, was elected president to succeed Dr. Harvey S. Brown, Freehold; J. Leclerc Snedeker, health officer of Burlington, vice-president, and N. J. Randolph Chandler, Plainfield, secretary-treasurer. The association indorsed several new health bills that are before the legislature, including the Blackwell measure authorizing boards of education to employ registered nurses; Senator Woodruff's bill providing for the pensioning of health officers, aged 65 years, after twenty-five years of service; the bill authorizing the sterilization of certain afflicted persons; the bill appropriating \$30,000 for educational work in combating tuberculosis and the bill allowing local boards to disclose the names of persons having communicable diseases.

Newark Health Report.—In January, 1924, there were 435 deaths in Newark, or a death rate of 11.7 per 1,000 of population. The principal causes of death were: Tuberculosis, 26 cases; Cancer, 28; apoplexy, 35; organic heart disease, 60; pneumonia, 73; Bright's disease, 27; congenital debility and malformation, 34; Cases of tuberculosis treated in clinics: In Department Clinics, 842; in Sanatorium Clinics, 72. Total number of births during January, 1012. The report states that more deaths occur now from heart disease than from tuberculosis. 10 years ago the rate from tuberculosis was 159.2 and organic heart diseases 140.9 per 100,000 in the United States. In 1920 it was tuberculosis, 114.2 and organic heart disease, 141.9 per 100,000.

Smallpox in Elizabeth.—Though thirteen cases of smallpox have been found in white families residing in the city, Health Officer Richards says there is no cause for alarm. These cases were found as the result of a doctor reporting a case of chicken pox. Only one of the thirteen had been vaccinated and that one the day before she was taken sick.

Whole-Time County Health Officer.—The whole-time county health officer fills in the gap between the State authorities and the county. He is the connecting link. He is constantly in touch with local needs. General principles are necessary, but each community has to have special modifications of these general principles. It is the health officer's duty to apply these principles to the best advantage, always bearing in mind the real conditions.—Chichester, P. M.: Virginia M. Monthly.

Lines of Health Legislation.—There are three lines of health legislation where all the

skill of a public health worker as an educator is demanded for success. First, when it is proposed to use the power of taxation in forwarding health work; second, when it is proposed to establish a new thought in public health policy; and third, when it is planned to turn the health policy of the government in a new direction.—R. G. Paterson, Hosp. Soc. Serv.

Shaping Proposed Health Legislation.—The shaping of health legislation may be viewed for present purposes as being wholly a legal problem, while the promotion of health legislation may be viewed as an educational one. Both phases of the work are usually carried on concurrently, with the emphasis at first on shaping the legislation and, later, on its promotion. Success in the promotion of such legislation depends upon a clear preception of the situation to be dealt with, a logical marshaling of the facts in the situation, a reasonable assurance that the proposed legislation will accomplish the desired end, and finally, the choice of methods in convincing the public that the proposed legislation is necessary.—R. G. Paterson: Hosp. Soc. Serv.

Clean Milk.—The Medical Milk Commission of Essex County publishes a Bi-Monthly Bulletin under that caption in the interest of the Medical Profession and the Public Health. They issue medical certificates for distribution among the medical profession and have reference to the product known as "Certified Milk." This milk is produced under a contract between the Medical Milk Commission of Essex County and the Fairfield Dairy of Fairfield, N. J., and the Medical Milk Commission of Union County and the Wood Brook Farms Dairy of Metuchen, N. J. The members of the Commission are: Drs. McEwen, Lehlbach, Murray, Bianchi, Vail, Wherry, Pinneo of Newark; McGee, West Orange; Runyon, South Orange.

Personal Notes

Dr. Thomas Barber, Phillipsburg, Senator of Warren County, has been appointed by Governor Silzer Chancery Clerk.

Dr. James Spencer Brown, Montclair, spent some time recently at Pinehurst, N. C.

Dr. G. Howard McFadden, Hackensack, recently retired from general practice and will devote his time hereafter to office practice and consultations.

Dr. Charles L. Ill, Newark, and wife, sailed last month for a ten days' trip to Bermuda.

Dr. Robert F. Ringland, Montclair, spent a few days last month in Atlantic City.

Dr. Elvira Dean Abell, Morristown, president of the County Tuberculosis Association, gave a series of lectures throughout the county last month on "Tuberculosis, Its Preventives and Cure," with lantern slides, Miss Headley the executive secretary assisting.

Dr. Jackson B. Pellett, Hamburg, and wife recently spent a few days at Haddonfield.

Journal of The Medical Society of New Jersey



Published on

the First Day of Every Month

Under the Direction

of the Committee on Publication

Vol. XXI, No. 5

ORANGE, N. J., MAY, 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

INSULIN TREATMENT OF DIABETES MELLITUS; REPORTS OF ELEVEN CASES.*

By Aaron E. Parsonnett, M.D.,

Attending Physician, Newark Beth Israel Hospital, Newark, N. J.

Though we are comparatively a small hospital, and a general hospital at that, still in a short time, i. e., in about two months, we had eleven diabetic ward cases. This simply corroborates the well-known prevalence of this disease in our community.

Among the eleven patients, we had ten Hebrews and one Gentile. This by no means supports the prevalent view that diabetes is a Hebrew disease, but we will explain the predominance of Jews in our series, because of our being nominally a Jewish Hospital.

In our series we had seven females and four males. This differs very markedly from big statistical records where we find that men are more affected. Most agree that there is a ration of 3:2.

The age incidence in our series is from twenty-eight to sixty-three years. This shows a disease of adult life.

As to the hereditary influence, we have found in four of our cases, where parents, brothers or cousins were the victims of the same malady.

The complaints offered on patients entering hospital varied a great deal. Some gave the classical symptoms of diabetes mellitus, as: Loss of weight, polyuria, nocturia, polyphasia, polydipsia, and itching of skin. Others, on the other hand, came in with complaints of nervousness, of pain in the back, pain in the legs, of pain in the right hip, and weakness. In other words, from the history and physical findings alone, in many cases a diagnosis of

this condition was impossible. This point merely shows once more the value of ordinary routine laboratory procedures, such as: Urine and blood examinations, which more and more become one of the essential means in diagnosis even in private practice of medicine.

The urine examination in all our cases immediately revealed the nature of the disease, as well as the extent. Almost all of them had a specific gravity varying from 1,034 to 1,045. Sugar from 3 per cent. to 8 per cent. Two of our cases on admission showed the presence of acetone and diacetic acid. There was one exception who was sent in with diagnosis of diabetes and whose chief complaints were: Great thirst, polyuria, nocturia, itching all over the body, weakness,—for three days had her urine sugar free, specific gravity 1,020, and blood sugar 125 mgs. per 100 c. c. Only when a full diet was given for two days, the urine showed a 5 per cent. of sugar and the blood sugar became 166 mgs. per 100 c. c. This simply shows how careful we must be before we make a diagnosis. The blood chemistry in our cases before we began treatment showed a blood sugar 137 mgs. per 100 c. c. to 334 mgs. per 100 c. c. One of our patients showed a blood sugar of 140 mgs. per 100 c. c., while the urine contained acetone and diacetic acid. We may summarize then that diabetes mellitus in the majority of cases is comparatively easy to diagnose, if we take the trouble to get a good history from the patient and we make a simple laboratory procedure an essential part of our medical armamentarium.

Before we reach the most essential feature of this paper, i. e., the matter of treatment of our diabetics, we will take the time to report some of the cases which showed special interesting features.

The first case is that of a woman sixty-one, Gentile, her chief complaint was pain

*Read before Clinical Society of Newark Beth Israel Hospital, February 6, 1924.

in the right hip of three weeks' duration and loss of weight—40 pounds in a few months. The physical examination was negative, except that she looked drowsy. The urine examination showed specific gravity 1,034, trace of albumin, $3\frac{1}{2}$ per cent. sugar, acetone 1 plus, and occasional Hyaline casts. The blood chemistry—Urea N.—33 mgs. per 100 c.c. uric acid—4 mgs. per 100 c.c. creatinine 1.8 sugar—300 mgs. per 100 c.c. Iletin units 5 T. I. D., was given immediately. Patient showed some improvement in a day, but refused all food. After three days, patient appeared drowsy again and urine became very bloody. Iletin was increased to $7\frac{1}{2}$ units T. I. D. x-ray picture of kidneys was immediately taken. The report came negative for any pathology. The urine became almost frank blood, while the total 24 hour output diminished to 160 c.c. and showed little or no sugar. The blood sugar, on the other hand, went up to 500 mgs. per 100 c. c. on the day of her death. Patient died after being ten days in the hospital. Clinical diagnosis was diabetes mellitus and probably malignancy in G. U. tract. An autopsy was done and the following was found: Heart, negative, aorta showed slight arteric sclerotic changes. Lungs: Negative. Free blood in the abdominal cavity. A ruptured aneurism of abdominal aorta about one inch above the bifurcation into the iliacs. Ureters were normal. Kidneys showed chronic interstitial nephritis, bladder—acute cystitis. From that we may conclude that patient was suffering from a mild diabetes for some time, not severe enough to give her any symptoms. The essential fact that brought her to the hospital was the pain in the right hip caused by the enlarging aneurism pressing upon the nerves of the lumbar plexus (which we failed to recognize). Death occurred due to rupture of the aneurism and probably due to uremia and coma as a result of pressure upon the ureters. To explain the frank blood in the urine is rather difficult, since the G. U. tract seemed normal, except for the acute cystitis, which usually does not cause such severe haematuria. We will leave that part for the pathologist to explain.

The next two cases in some respects are similar because from physical findings we came to the conclusion that both had some glandular deficiency, which may have caused the sugar in the urine, and the hyper-glycemia.

The first case was a woman of thirty-five, Hebrew, came in with chief complaint

of pain in the back. The previous history was occasional nocturia, and pruritis valvae, very nervous for the last few years and complained of palpitations. The menstrual history was very irregular for the last few years. Had one period in the last year. The physical examination was negative, except she appeared very big and clumsy. Had exceptionally large jaws. Teeth widely separated. Hands and feet very large. Skin thick. Urine, specific gravity 1,034, sugar 5 per cent., acetone negative. Blood sugar 334 mgms. per 100 c. c. Our general treatment for diabetes, which I will discuss later, was instituted, but the sugar in the urine could not be controlled successfully. At times it disappeared and a day later it appeared again. Whether it was because patient was very unreliable and did not co-operate with us at all, or the sugar was a result of some deficiency other than one in the internal secretion of the pancreas, we could not establish. Patient was stealing food, refused examination of eye-grounds, refused x-ray of skull. We made her sign a release and she left unimproved. But from the history and physical findings, we have a right to assume that it was a case of acromegaly, with enlargement of the sellatursica which irritated the posterior lobe of the hypophysis, the result of which is a decreased tolerance of carbohydrates with a resultant hyperglycemia and glycosuria.

The other case is that of a woman thirty-eight, Hebrew, whose chief complaints were itching, ulcerations of the skin, sleeplessness and nervousness. The history was negative, except for the menstrual history which was very irregular for the last ten years. She had one miscarriage, she had no children. Physical examination was negative, except for a few ulcerations on the abdomen and her face was overgrown with hair. The urine showed specific gravity 1,040, sugar 5 per cent., acetone negative. The blood sugar 288 mgs. per 100 c.c. While in the hospital we could observe the patient better. At times she acted very queerly—hysterical laughter, or marked depression, crying, accusing husband of disloyalty and wishing to get rid of her. Later we found out that patient was confined to an insane asylum for months. A diet of 1,800 calories and 5 units of insulin relieved her of the itching and other symptoms and the urine became sugar free and the blood sugar to 99 mgs. per 100 c.c. X-ray of skull was negative. The examination of the eye grounds was negative, but from the history and physical findings, we probably had to deal with some

polyglandular deficiency, the exact nature of which we could not well establish.

In our treatment of the patient, we adhered as far as practicable to the following principles: First, to have the patient's urine sugar-free and blood sugar at about the normal level, which is 80-125 mgs. per 100 c.c. Secondly, to give a diet, which should answer the normal requirements of the body for waste of tissue, heat and energy and also not to allow the accumulation of fatty acids which may result in diabetic coma. Third, to increase the tolerance for COH's. Fourth, to give patient a sustaining and palatable diet with the *least amount of the new remedy* Insulin. We had also in mind to adhere to the COH fatty acid reaction, i.e., to give enough COH's to assure fat metabolism. From experimental studies it was established, to attain that end, the human body needs about 1 gram of glucose to about $1\frac{1}{2}$ -2 grams of fat. The latter varies a great deal with the weight of patient, obesity, etc. Having those principles in mind, we proceeded as follows, practically in all of our cases with one or two exceptions.

We put patient on starvation diet. We allowed him broth, (clear) tea, coffee and whiskey to the amount of a few ounces. In our experience, the so-called true diabetics, except the cases which I reported above, had the urine sugar free in from one to three days. Also, another patient whose urine repeatedly showed some sugar, confessed that he was stealing. The blood sugar in most cases showed a marked reduction and in some cases went down to normal. Then a diet was prepared with the intention of establishing the tolerance for proteins and COH metabolism, having the so-called COH fatty-acid ratio in mind. First we prepared a diet of about 1,000 to 1,200 calories, C-30-40 grams; P-30-45 grams; fats 70-80 grams; if urine showed sugar, insulin was instituted immediately, because this showed that the Islands of Langerhan of the pancreas which supply the internal secretion, were for the most part destroyed and a new supply had to be given in order to carry on the normal activities of the body. Some may say that sugar showed itself in the urine because of the immediate introduction of 30-40 grams of COH'S and 35-45 grams of proteins, of which 60 per cent. is also glucose, but in order to avoid the accumulation of fatty acids in the body with a resultant acidosis, we had to give such a diet; while to give a proportional lower diet would be incom-

patible with the normal requirements of the body and the normal activities of an individual. However, most of our cases did not show any sugar on a diet as above mentioned. We then decreased the diet to about 1,400 and 1,500 calories with the same proportion of carbohydrates, proteids and fats, taking in consideration the weight and activities of the patient. If they did not show sugar, and they were satisfied with the diet, we usually increased to about 1,600 calories and we considered then non-iletin cases. In our series we had only two. These patients were kept in the hospital for about two weeks, with instructions as to the diet, as to how to weigh the food and they were discharged as improved. They returned to us for the last six or eight weeks and their urine is still sugar-free and blood sugar 150 mgs. per 100 c. c. They are perfectly content with the diet, and carry on their normal activities, such as housework.

Other cases either showed some sugar in the urine on the same diet or they looked as if they were not getting enough nourishment. For such patients, we increased the diet to about 1,800 to 2,200 calories (taking the weight and activities into consideration) and started them on insulin. We usually started with units 3 (of the U-20 T. I. D. 20 min. P. C.). If they were not sugar-free we increased the insulin to 4, 5, 7, units and so on, until we accomplished that end on the diet we desired. In our series to one patient with a diet of 2,100 calories, COH C-60, P-70, F-145 grams, we had to give about 12 units of insulin T. I. D. in order to have him sugar-free. When a patient was sugar-free for a few day, we reduced the insulin, and most continued to be sugar-free.

This showed that a certain tolerance was established. Our next step was to teach the patients or relatives how to weigh the foods and now to inject the insulin. Only in a limited number of cases, two, we succeeded fully to continue the diet and insulin treatment home. The rest could not do it, either due to lack of intelligence, lack of financial means, or too much trouble for the patient to take care of himself.

We may summarize, then, from our limited experience, that the treatment of diabetics must still follow the well established principles of metabolism of the human body and the scrupulous dietary principles which were followed for the last few years, and that iletin has very great limitations so far: First, we saw that not all of

the patients required that; secondly, to a vast majority, it is unreachable, either because of lack of intelligence, financial means, and finally, because of the inconvenience and discomfort caused by the injections of this new remedy.

DISCUSSION.

Dr. Theodore Teimer.—I want to congratulate Dr. Parsonnet on his paper. He has shown that one may draw valuable conclusions from comparatively small material. The results in his series on eleven cases were good. Methods of procedure are, of course, individual, and there is no need for uniformity. It is of importance to determine when insulin should and when it should not be used. There are differences of opinion as to the amount of carbohydrates that should be metabolized in a given case, and as to the relative proportion of proteins, fats, and carbohydrates to accomplish the desired result. Study of medical literature proves that a clearer understanding of the problem of treating the individual case begins to prevail. It is obvious that where dietary treatment is sufficient, insulin should not be used. Even when we have to deal with a borderline case we prefer to treat by diet alone. As Dr. Parsonnet pointed out, patients often lack the necessary intelligence, will-power, or finances.

The use of insulin does not do away with the necessity of being accurate with the diet. On the contrary greater care must be exercised in balancing the diet with the insulin dosage. Insulin, of course, does not "cure" diabetes. It merely supplies a deficiency, and should be restricted to the actual needs. These needs fluctuate with complications, even minor ones, as colds, indigestion, etc. Greater fluctuations occur in injections. The slightest infection will raise the blood-sugar. It is difficult for patients to appreciate these conditions and they easily become discouraged and feel helpless. All this emphasizes the preference we give to dietary treatment when it will meet the requirements. These should not provide for a mere existence, but also for capacity to work in fair comfort.

Cases with complications should not be so strictly limited. Cases of general arteriosclerosis, with involvement of the pancreas and resultant hyperglycemia and glycosuria of moderate degree should, in my opinion, be treated with liberal amounts of carbohydrates, even if it necessitates the use of insulin. There are cases in which the circulation in the legs and feet is embarrassed and local gangrene develops. Such cases, in my experience, were greatly benefited by a liberal carbohydrate allowance. A feeling of warmth is produced in the extremity, and the general symptoms are improved.

Another group of cases are those with complications in the eye. We get eye symptoms often, early in the disease. We give insulin and carbohydrates in this condition also and usually arrest the development. Then there are those diabetics threatened with infections, such as boils and carbuncles. Such cases were saved with the aid of the pancreatic hormone, under the most adverse conditions where the patient's life was despaired of. In-

sulin has also proved useful in our experiences in cases of pneumonia, erysipelas,—complicating diabetes. I think the use of insulin will not remain limited to diabetes alone. Many observations point in this direction.

Dr. Asher Yaguda.—The autopsy findings of the woman referred to in Dr. Parsonnet's paper, showed as the primary cause of death rupture of the aorta above the bifurcation into the iliacs. There was marked arteriosclerosis with calcification of the media. The rupture may have occurred during straining at stool. The rupture was an inch and a half above the bifurcation of the aorta. The kidneys and ureters were negative. There was no pressure on the ureter as evidenced by the absence of hydronephrosis. The gross haematuria may have been due to the pressure on the inferior vena cava and bladder wall of the hematoma with passive congestion.

About diabetes, there has been very little left unsaid. I am glad to see the turn that the treatment has taken. The main object when insulin came out, was to nourish the starved patient. The patients are now getting tired of taking insulin. The most important thing to keep in mind in any treatment of diabetes, whether with insulin or without insulin, is to prevent a loss of tolerance and if possible, to increase the tolerance. I have observed a number of cases for over a year, in whom large doses of insulin and a liberal diet brought no gain in tolerance. In some cases, treated with insulin, in which the blood sugar was kept at a normal level, a gain in tolerance was observed, but this was probably not greater than the tolerance which would have been attained under strict dietetic treatment without insulin. The blood sugar should be kept at a normal level in all patients. Hyperglycemia will certainly not help the tolerance and it is a well-known fact that arteriosclerosis, cataract and many of the other diabetic complications, are due in part, at least, to a high blood sugar.

Dr. Parsonnet has certainly done a great deal towards standardizing the treatment of diabetics at this hospital and should be congratulated for his wonderful work.

Dr. Julius Levy.—I want to mention a new theory. Talheimer says that there is a normal glycolysis in the blood and that insulin stimulates this process in the nature of a hormone.

Dr. Andrew Rados.—I don't want to discuss diabetes, except from the standpoint of the Ophthalmologist. Hypertonia of the eye only occurs in diabetic coma. Very rarely it occurs in infectious diseases. The other important eye symptoms is a transitory hypermetropia. If the refractometric index of the aqueous and vitreous humor changes very suddenly, one must think of diabetes.

Dr. Rostow.—Cereal starches give an acid ash. The others give an alkaline ash. It is not so important to reduce the sugar in the urine in arteriosclerosis. Their hearts begin to go bad. A vegetable diet with an alkaline ash is desirable. The importance of this is that it lessens the possibility of acidosis. The patients gain weight and feel better. The dietetic treatment should be long. I think that more potatoes should be eaten.

Dr. Parsonnet.—Dr. Levy has previously

spoken to me about the new theory of glycolysis in the blood, but I haven't considered it sufficiently to discuss it. I am very much indebted to Dr. Joseph Skwirsky for his valuable assistance in gathering the statistics connected with the cases on my service.

SINUS THROMBOSIS*

By Talbot R. Chambers, M.D., F.A.C.S.,
Jersey City.

An exhaustively comprehensive study cannot be attempted in the time limited as it is, but the essentials must prove of value.

Sinus thrombosis is not, comparatively speaking, a very common disease, but it is a very serious one. It is of chief interest to the otologist, but the general practitioner recognizes its importance.

The term sinus thrombosis practically always refers to the lateral sinus. The veins in the head are without valves and are termed sinus because of their large size. The lateral sinus lies in the splitting of the dura; i. e., brain or bone on one side of its wall and lumen on the other.

The lateral sinus commences at the torcula herophila, passes in a horizontal direction in a groove of the occipital bone for a distance of about six centimeters to the intersection of the three bones, occipital, parietal and temporal. Here it curves at a point called the heel in a downward direction, making a curve like the Greek letter Sigma and hence is called the sigmoid sinus. About one cm. from the end of the petrous bone it suddenly curves up to form the jugular bulb. It continues down the neck as the internal jugular vein. At the bulb the inferior petrosal coming from the cavernous sinus, empties into it and many smaller veins from the labyrinth and tympanum. On the dried specimen can be seen a dehiscence of bone which may in life have been the cause of phlebitis. The importance of the anatomy of these parts is seen when one considers the great majority of sinus thrombosis originate right here.

Etiology.—Inflammation having started from a dehiscence of bone or from phlebitis of one or more of the small veins emptying into the sinus, a deposit of fibrin from the blood passing through the vein, increases until it obstructs the flow of blood. The thrombus may extend to the torcula and even to the other lateral sinus and also up the longitudinal. In front at the bulb it may descend to the heart filling the jugular;

it may extend through the inferior petrosal to the cavernous and interiorly into the brain. It may become organized and only be recognized after death. However, the rule is it becomes infected. Pus and debris are distributed to various parts of the body. In the lungs, chest pains and foetid sputum show presence of lung abscess. If osteomalachia of the mastoid starts up metastatic perisinusitis, internal infection soon occurs with formation of a purulent thrombus. A thrombus reaching the cavernous sinus causes swelling of the eyes and loss of vision with muscular derangement following. When the veins carry pus to the brain, brain abscess occurs. At a mastoid operation if the sinus be infected a chill may not occur till the ninth day which gives notice of sinus infection.

Symptoms are local and general. They depend upon parts involved, back, down, in or outward. There is local mastoid headache which may extend to frontal or occipital. It is severe, intense and not relievable.

There is swelling over the sinus and jugular, if involved. Pain on pressure, same regions. In health pressure over the jugular distends the temporal vessels but if the jugular be closed, no effect is observed on pressure. A hard cord may be felt supplanting the jugular. Exudation about the jugular may cause pressure symptoms on the 9th, 10th, 11th and 12th nerves. Even the phrenic may be pressed upon producing symptoms.

The blood picture is that of leucocytosis of perhaps 50,000 whites and 95 per cent. polies. A streptococcus is termed benign as compared with a pneumococcic infection which later is termed malignant.

X-ray pictures sometimes confirm suspicion of sinus thrombosis. The liver and spleen are generally enlarged.

Symptoms, general. The fever is the fever of sepsis. It jumps to 103, 104 or 105. There are remissions during which the patient feels good and wants to get up. A chill occurs in only about 50 per cent. of the cases; is prolonged and recurs while in brain abscess it is slight, of short duration and does not recur. A very depressing sweat accompanies marked *asthenia*. Pulse accelerates with temperature. Vomiting according to some observers is without nausea, the others note nausea as the cause of vomiting. It is often projectile. *Mentality* is depraved during the fever to be relieved during remissions. Neither the pupils of the eyes nor fundi ordinarily show any

*Read before the Jersey City Practitioner's Club, February 13, 1924.

change until the cavernous sinus is involved when blindness and squint present. Hunter Tod claims 50 per cent. have optic neuritis. There is always an acute or chronic running ear or history of one. The question of primary sinus thrombosis has been theorized about but a searching investigation will develop the fact that the ear received some attention or caused some concern, little though it may have been. The truth being the ear discharge was brought to a stop but the infection of the mastoid cells beyond had slumbered until aroused to activity.

Differential Diagnosis.—This is most interesting. Brain abscess, tumor or cyst; typhoid fever, broncho-pneumonia or malaria have all been mistakenly diagnosed when sinus thrombosis was the *causa belli*.

Temperature.—Brain tumor or cyst has no temperature ordinarily. Brain abscess has a low nonfluctuating rise. Typhoid fever, broncho-pneumonia and malaria have distinguishing features generally.

Pulse.—Brain tumor slow ordinarily. Brain abscess possible bacteriemia. Meningitis high leucocytosis but minus germs. It should be remembered there may be high whites by several thousands for several days after administration of ether. Spinal fluid has high cell count with increase of globulin and albumin in both meningitis and sinus thrombosis. With brain tumor there is sugar. Vomiting of meningitis is projectile without nausea. Same in cerebellar tumor or abscess. *Skin.*—The tache cerebrale of cerebral meningitis is well-known.

Reflexes are according to the nerves or nerve centres involved. Convulsions are positive signs of cerebral involvement except in children when the administration of castor oil shows indigestion as cause. Paralysis and changes in sensation are due to cerebral irritation and pressure. The contagious fevers have their blood pictures. Some of their symptoms are very confusing but elimination obtains a diagnosis. In diseases, all classical symptoms are seldom all present, especially in brain diseases.

Mygind of Copenhagen found that out of 207 brain cases, 50 per cent. were sinus thrombosis and 20 per cent. brain abscess.

Sinus thrombosis is more frequent with chronic running ears than with acute. A typical case more frequently with children. If a chronic running ear case has a chill and a two or three day fever suspect a sinus thrombosis when a good dose of castor oil or calomel fails to relieve symptoms. A temperature of 106 in such a case has been cured by a purgation. ALL chronic

running ears should be examined for cholesteioma shreds. If any found in the discharge, a mastoid operation should be done at once. Such a case is threatened with disastrous ending if permitted to go uninterfered with.

Meningitis due to blood infection is fatal and operation is useless. Icterus, hemorrhagic jaundice after mastoid operation is forerunner of a fatal issue.

Papillodema and papillitis show circulatory disturbances at the corpora quadrigemina and optic thalamus. Hydro-cephalus or internal pressure are to be expected in brain tumor, but a brain tumor may obtain a very large size without these symptoms. As a rule sinus thrombosis has none of these symptoms, though it is the most frequent cause of cerebellar abscess. Dizziness and disorientation show involvement of the semi-circular canals and are not a sinus symptom except as complication due to advanced pathology involving the internal ear.

Treatment Is Operative.—If on opening the mastoid, one finds pus and granulations covering the sinus, it does not necessarily mean the sinus is obstructed by a thrombus. Very many cases have been found with this condition and the patient recovered with the sinus unopened. Great care is to be taken to leave undisturbed the granulations as they may be acting as a protective covering to the sinus. A sinus has been wounded not infrequently by a clean cut of the knife or a sharp chisel without any outward result. If there be a clot as found with hypodermic needle or knife cut, it is removed and a plug of iodoform gauze is used as pressure to stop the hemorrhage beyond the clot. All the thrombus must be removed. If the bulb is involved, the jugular must be tied, preferably at the clavicle even if the pus remains between the ligature and heart. Eagleton, Hays, Phillips and others have reported cases thus treated who have recovered. The first step on making a diagnosis of sinus thrombosis according to Hays is to administer a stock vaccine hypodermically and it is possible recovery may take place before the autogenous vaccine which takes four days in making, is ready.

Lester Unger (Laryngoscope April, 1923), says transfusion in bacteriemia, in the first place, maintains the proper amount of hemoglobin and red cells; secondly, supports; and thirdly overcomes the bacteriemia. Harold Hays (ibid) would not open a sinus thrombosis until a transfusion from an immunized donor had failed. Even after opening the sinus, the temperature remain-

ing up, because some of the bacteria are still left in the blood, a transfusion quickly brings about a cure. He says he has seen quite a few cases where 500 c. c. from a father or brother has reduced the temperature to normal and restored health. Both Hays and Phillips (Jour. A. M. A., Aug. 25, 1923) are authority for the statement that sinus thrombosis has been cured by repeated transfusions in cases where blood from the sinus proved negative. They state children comfortably receive 300 to 400 c. c. which may be repeated in two or three days. Unger (Laryngoscope February, 1923), says a transfusion from ordinary individual is of some, although not very great value as a curative measure *except* in cases where the source of the infection is the mastoid.

McFarland (Jour. A. M. A. August 25, 1923), reported a double mastoid but he was unable to determine which sinus was infected. Several transfusions of blood were employed and the patient was recovered in two weeks. He had a second similar case.

The operation for sinus thrombosis is first, to open the mastoid, clearing out all the infected cells and if the sinus plate is not eroded, to open and remove it leaving the sinus bare and uncovered. If a hypodermic fails to find blood, there must be a clot. This is removed and the sinus eliminated and closed off by pressure of gauze packs at both ends till blood flow is stopped. Every one is allowed to have his own opinion and it seems to the author, the safest plan is *always* to do a radical operation which simply means removing the bone covering over the iter ad antrum. Under this sheif of bone lodges cholesteioma which is very difficult to thoroughly eradicate by syringing even aided by curettage. Any debris allowed to remain, keeps the wound from healing and endangers the result.

If a perisinusitis is found and the sinus throbs and looks clot free, it were safer to leave the granulations alone, simply placing an iodoform gauze over it and partially closing the wound when nature takes care of results and later on the wound may be entirely closed.

Brain abscess 25 per cent. recover. Sinus thrombosis before brain abscess or meningeal complications, with quick operation a 100 per cent. recovery should be expected.

Recapitulation.—All sinus thrombosis cases come from a running ear, acute or chronic. If a running ear is not dried up in a month examine carefully the discharge

for cholesteioma which if found, calls for mastoid operation at once and probably it had better be a radical one. Make good use of laboratory and x-ray. Leukocytosis and high polys mean sinus thrombosis probably. The x-ray may confirm suspicions. Too much dependence must not be placed on laboratory and x-ray findings. The general appearance of the patient is a fairly reliable index. If sinus thrombosis is diagnosed it would do no harm to give a transfusion of blood at once, some relative acting as donor.

A delay in attacking the disease increases the danger immensely and a too previous operation were infinitely better, being without danger.

A note of warning has been sounded which perhaps, it would be wise to heed. So many spinal taps are being made every day, an unnecessary fatal issue may follow or accompany the tap where the pressure is very high. Weak vessels have suddenly given way in the ventricles and the shock proved fatal at once.

Lastly, every fatal case should yield a post-mortem examination. More light is needed for diagnosis of brain diseases and this with due respect to Cushing, Ayer, the Mayos, Eagleton in this country and the great men abroad.

THE FUNCTIONAL ELEMENTS IN ORGANIC NERVOUS DISEASES AND OTHER DISORDERS.*

By David Nathan, M.D.,

Assistant Neurologist, Mt. Sinai and Northwestern General Hospital, Philadelphia;

Consultant in Neurology, State Hospital for the Insane, Norristown, Pennsylvania.

The word "functional" is here loosely applied as it is by the profession and others and means a condition or conditions for which one has not a ready pathology—where the material basis cannot be seen or felt—and as such do I use it here.

The functional element is often the most disabling one in organic nervous disease as, it is scarcely less so in many disorders showing gross pathological changes in organs outside the nervous system and a patient's reaction to this or that disease will depend greatly upon his personality—that sum of characteristics which represent a man's real being in a far higher degree than his physical peculiarities—so it is one must

*Read before the Mt. Sinai Clinical Society, Philadelphia, Pa., February 26, 1924.

reckon with man rather than types of disease which prey upon his flesh.

The largest group into which the symptoms fall which are functional are the psycho-neuroses; these are often associated with and fore-shadow organic nervous disease for long periods of time before signs of the basic lesion present.

Hysteria and Neurasthenia are the types which predominate and which are so classical in their symptomatology when there is not one other clinical sign of organic disease, that one does not anticipate what material basis there is until time presents organic signs which are recognized by the most mediocre.

Disseminated sclerosis presents for varying periods before the disease is established, typical hysterical symptoms, in fact these may be associated with the condition throughout its course. Dementia precox shows hysterical manifestations in many cases for a long time before the true nature of the psychosis is discerned.

It cannot be gainsaid that eternal observation in most cases for many months will be necessary to separate the wheat from the chaff, especially is this so in organic nervous disease where function is disturbed in the realm of the psyche at a time when objective physical findings are behind the screen.

Neurasthenic symptoms are much in evidence in neuro-syphilis long before the physical crippling occurs, and this recalls to mind a patient who was referred to me with diagnosis of melancholia and neurasthenia made by able men; I concurred in the diagnosis of neurasthenia for at the time there was not one objective physical finding, blood negative, spinal fluid reported anticomplementary (which means nothing); later course was that of general paralysis of the insane with death inside 18 months.

Emotional display is common in organic nervous disease, especially seen in lesions of the basal ganglia though, much of it may be functional. Other psychic disturbances of the intellectual sphere may have a definite organic basis and run concomitantly with other physical symptoms or precede for a time other signs.

During the remissions which are so frequent in general paralysis and disseminated sclerosis—there may be nothing but functional symptoms. The remissions are probably due to slowing up of the pathological process rather than an arrest.

Epilepsy and epileptoid seizures may be part of, or associated with physical disease;

the histological lesions may be so located that even the most heated imagination could not discover any relationship between them and the clinical manifestations—such is the inexorable logic of pathology.

Pain is a relative sensation and varies as widely in both kind and degree as do individual personalities who suffer with it; it is frequently psychic in origin and depends upon no known organic lesion; again, it may be of physical genesis and due to disturbances of any tissue.

Sciatica and neuritis of other peripheral nerves are diagnosed as such by physicians, on the patient's complaints of pain in one or other location. Neuritis is a definite organic nerve condition and presents definite objective signs. I am satisfied that only a small percentage of cases diagnosed as neuritis have an organic nervous basis, and yet the functional elements can be accurately determined in most cases if, objective rather than subjective signs be taken as the criterion.

Precordial, epigastric and other somatic pains are frequent in tabes and organic nervous disease due to an organic pathology; they are also frequent in the psycho-neuroses and psychoses.

Tremors and involuntary movements vary much in type; most of them present a distinctive get-up which serves to place them in the organic or functional class.

It seems to me germane to this paper to go into at greater length the most frequent of functional conditions, viz. hysteria, for if one can exclude the hysterical element in organic nervous disease, and in most other diseases, much of the diagnostic haze has been lifted.

Hysteria may stimulate any symptom or group of symptoms and whatever may be said about the genotype essential for a life-long show of hysterical symptoms—there is no doubt that everyone is a potential subject, albeit he need not disclose a front papered with stigmata; I have seen so many upon whom I both placed and removed various stigmata by mere suggestion, and I've never seen a case which I could assure myself had stigmata which had not been placed there by some one who zealously and openly searched for them. I am sure that all of us are suggestible to a greater or lesser degree and I believe that if the stimulus be strong enough or, often enough repeated, everyone would present hysterical symptoms. Our reactions by auto—and hetero—suggestion vary as differed our heredity and entourage. May I quote

Maudsley? "there is a destiny made for a man by his ancestors, and no one can elude, were he able to attempt it, the tyranny of his organization," add to this prenatal being, a journey down the years in an environment which varied between brigandage and the publication of tracts, and we have the finished product reacting to this or that ill in his own inimitable way. Since then, hysteria may present any symptoms, we must rely upon definite signs of organic disease which cannot be, or at least, are not simulated. There are many signs and postures which are typical of organic nervous disease and whether there be hysterical symptoms or, the patient be a psychasthenic, constitutional psychopath or psychotic, these signs are the immutable evidence of the organic background. The functional element is as disabling in disease of parts not intrinsically nervous and a therapy directed towards its removal is as earnestly demanded as is that towards physical restoration. It is not a far cry from the title of this paper to speak a few words of treatment and to urge the benefit which properly applied psychotherapy will give in the removal of the functional element, removing in many cases at least 50 per cent. of the disability, whereby the patient makes a social adjustment.

By psychotherapy I mean suggestion, persuasion, encouragement and a hopeful outlook—above all optimism in the treatment of patients as, in the behaviour of individual to individual, exalts—eliminating depression and fear. The affective sphere which has to do with ethics, culture and the humanities deserves as much consideration as does the intellectual with all its abstruse dignity.

SURGICAL TREATMENT OF THE SEQUELAE OF PNEUMONIA*

By **George Blackburne, M.D.,**
East Orange, N. J.

The surgical sequelae of pneumonia most commonly noted are: Empyema, abscess of the lung, pericarditis, peritonitis, parotitis, and arthritis.¹ Of these I shall only attempt to discuss the treatment of empyema, which occurs in about three per cent. of all cases, and abscess of the lung, which, when identified and treated as such, is a rather rare complication.

The mortality in empyema is very high, that in the army camps during the influenza epidemic being figured at 32 per cent. The mortality in civil life, following the ordinary pneumonia cases, however, is very much lower than this. As in all conditions where the mortality is high, we have a great variety of treatment to consider.

We have been overwhelmed in recent years by many so-called new treatments for empyema, this or that man, including myself at one time,² strongly advocating a certain line of treatment and publishing a series of cases to substantiate our opinions. As a matter of history,³ there has been no new treatment of empyema discovered in recent times. In Ancient Greece they operated for this condition, inserted drains and irrigated the cavity with warm wine and oil; and Hippocrates is quoted as particularly advising against too early intervention. Is this not almost identical with most of our modern methods? In 1579, Parè treated empyema by resection of ribs; in the 17th Century Horstus advocated the frequent use of the trocar; and Bass, in the 18th Century, suggested excluding air from the cavity by a valvular opening.

The keynote of the treatment of empyema today is to delay operation until all signs of the pneumonia have subsided, and then to perform a dependent rib resection under local anesthesia. Aspiration and injection of an antiseptic, the open method and the closed method, all have their advocates, and I am not going to attempt to discuss the merits of technique of these various procedures, except to state, that while simple aspiration and irrigation will occasionally result in a cure, the treatment should not be generally advocated, as a large percentage of these cases have to be operated upon and drained at a later date. Following is the outline of a plan of operation that has been uniformly satisfactory in the hands of myself and associates for the last few years. Our immediate operative mortality has been nil, and our results are very favorable as compared with those using the various methods above mentioned.

The patient should have a thorough clinical and fluoroscopic examination, and a diagnostic puncture, to determine the site and extent of the process, and to make sure that the pneumonic process has completely resolved. Repeated aspiration

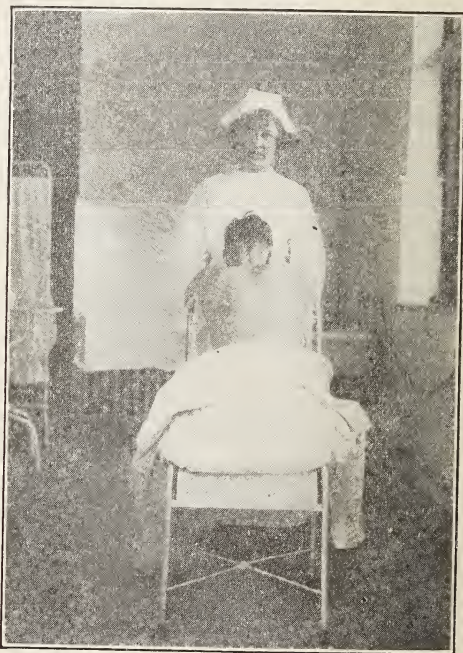
*Read before the Academy of Medicine of Northern New Jersey, March 11, 1924.

is indicated, if the collection is large, and the pneumonia has not subsided. In this way many critical cases can be successfully carried through.

Several years ago, after seeing two deaths on the table, I became convinced that all empyema cases should be done under local anesthesia, and adopted the following method which is a combination of the French sitting posture, as outlined by P. de la Villeon⁴, and the infiltration method, described by Morris and Horsley⁵.

The patient (and I have operated in this manner upon young children), is given a preliminary hypodermic of morphine and atropine, and is placed straddling a chair with head and arms hanging over the back. We thus get a minimum respiratory embarrassment and a maximum separation of the ribs. Previous examination has disclosed the extent of the involvement, and the lowest avenue of approach, which will usually be found to be by a three-inch excision of the 8th rib on the right, or the 9th rib on the left side, in the mid-scapular line. Care must be exercised that the peritoneal cavity is not accidentally opened, due to adhesions in the lower chest. This is not a very rare occurrence, and I have seen it happen on two different occasions in the hands of experienced surgeons who quickly recognized the fact and closed the wound.

About 3 ounces of $\frac{1}{2}\%$ novocain solution is used through a long, thin needle. The needle is first thrust through the skin, just beyond the angle of the rib, injecting a little solution at the same time, until the under surface of the rib is reached. The point is now directed into the sub-costal groove and 5 c.c. is injected into the region of the intercostal nerve. Without withdrawing needle, the periosteum on the outer surface of the rib is injected as far as possible, then the intercostal spaces above and below the rib, and lastly the skin and subcutaneous tissue along the line of the proposed incision. This is all done with the one needle puncture, and the same procedure is repeated, starting about the middle of the infiltrated area and working forward, of course not injecting the nerve a second time.



Position of patient for resection of rib.

The operation is now begun, the surgeon standing, or sitting, behind the patient, with an attendant steadying the patient from in front. After incising over the rib and separating the periosteum, care in using the rib shears is necessary; I prefer to cut the rib with the shears at right angles to the body rather than trying to force them under the rib. After incising the pleura, the pus should be allowed to run out slowly, larger chunks being later expelled by coughing. Two large rubber drainage tubes are inserted, guarded with safety pins, and dressings



Injecting novocain solution preparatory to resection of rib.

are applied. The patient is given an automobile inner tube, with the valve removed, and instructed to inflate it thoroughly every hour. This generally results in a prompt obliterating of cavity and cure of the case.

If there is a tendency to chronicity, we irrigate the cavity three times a day with Dakins' solution and look for the cause, the most frequent being, the incomplete drainage of pockets, inadequate dependent drainage, necrosis of the rib margins, or a foreign body, as a lost drainage tube⁶. Decortication is indicated only in those chronic cases of long standing where other methods have failed.

Abscess of the lung, which has been located by the fluoroscope, should be first treated expectantly⁷ by postural drainage, good food, hygiene and, in some cases, by artificial pneumo thorax.⁸ The admonitions about not operating too early in empyema cases holds doubly true in abscess of the lung, which should not be treated surgically so long as the patient is showing any improvement under medical care.

If surgical intervention is necessary, operation should also be done under local anesthesia, using the same technique as described for empyema, but opening as nearly as possible over the area. If the pleura is adherent, the operation can be completed in one stage; otherwise, locate the abscess by palpation and inspection of the visceral pleura, which will usually be found to be greyish and thickened⁸. The lung is sutured to the chest wall in one or two places, and gauze packed around the area for three days to obtain adhesions. The cavity is now entered with a blunt needle and the opening enlarged to admit a finger. The cautery may be used to control bleeding⁹. A soft, rubber tube, surrounded with gauze, is inserted and changed every 24 hours. These cases must be drained for a long period, as the only hope for cure is in the obliteration of the cavity by scar tissue.

93 Hawthorne Ave., East Orange, N. J.

References:

1. Osler—Principles and Practice of Medicine.
2. Blackburne—Journal Med. Soc. of N. J., Sept., 1922.
3. Schochet—Intern. Abstract of Surg., Mar., 1923.
4. P. de la Villeon—Presse Med., Oct. 11 1919.
5. Morris & Horsley—Lancet, Dec. 12, 1918.
6. Hedblom—A. M. A., Sept. 22, 1923.

7. Homans—Boston Med. & Surg. Jour., Apr. 19, 1923.

8. Harrell—Virg. Med. Monthly, Jan., 1923.

9. Whittemore—Boston Med. & Surg. Jour., Apr. 5, 1923.

"AS OTHERS SEE US."*

Presidential Address

By Dr. William B. Cutts.

President of the Providence Medical Asso'n.

As prescribed by the by-laws, it becomes my duty at this time to address you on a subject dealing especially with the work and needs of this association. In casting about for such a subject, I soon found that there were very few which had not already been treated by some medical man, under similar circumstances. Indeed, it is not improbable that some of the thoughts presented tonight may have been called to your attention at some time or other. However, if such be the case, it is hoped that the offense will be overlooked, as it certainly is not intentional.

Today, we are living in an age of transition. The old is being torn down and the new built up. In medicine, law, religion, politics and industry—in fact in every phase of civilized activity, changes are occurring with astonishing rapidity. New combinations are being formed, with results that are unforeseen, and often startling.

In connection with such innovations then, it should cause no surprise that the relations of the medical profession, both as individuals toward one another, and as a collective body toward the general public, are arranging themselves along new lines. It is probably true that medical men comprise one of the most conservative and stable of the professions. For this reason it would be expected that the profession would feel the effects of these changing conditions of life, least of all. Nevertheless, it must be admitted, that physicians face a different world today from that in which our medical fathers lived. Among the changes referred to may be noted the following:

The rise and flourish of the so-called cults; the tendency toward commercialism among regular practitioners; excessive specialization, and concentration of the profession in cities.

It is to the first of these that I would

*Read before the Providence Medical Association January 7, 1924.

especially call your attention this evening. Let us ask ourselves for a moment the reason for the existence of the new cults, such as osteopathy, chiropractic, Christian Science, mental healing, etc.

In the first place, is it not because of the general restlessness, characteristic of the age, and because people are looking for innovations and anxious to try anything new? Again, is it not partly because the time-honored, regular methods of treatment have, at times, failed to relieve the public of many of its real or fancied ills? May it not also be another reason that in the zealous pursuit of scientific attainment, and attempts at solving the baffling problems of disease, medical men have, to a certain extent, been nonchalant in the treatment of the minor ills and discomforts afflicting the human race?

Let us see! In a recent number of the Illinois Medical Journal there appeared the report of a committee of the Society, which had made an investigation to ascertain what proportion of the general public were employing healing agencies, other than the medical profession, and so far as possible, the reason for such action. During this investigation, 6,772 persons in all walks of life, from society leaders to hold carriers, were interviewed. Of this number, it was found that only 931, or a little over 13%, had never patronized any of the so-called cults, while only 384 of this number had no curiosity about them, and no intention of trying one of them at some time or other.

Of the remaining, 5,841, who were opposed to the medical profession, or who had employed other forms of healing, only 7% actually had a grievance against the medical profession, on account of some personal matter, such as real or imagined malpractice. The other 93% had confused and distorted notions of the medical profession; of its relation to social and scientific progress, and of its long and laborious preparation for practice. In the words of another, "To many people had no conception of what M. D. meant; to them it divided honors with such titles as D. Ch. and worse."

In the report referred to, the reasons given by the 5,842 people for dissatisfaction with the doctors are classified and grouped under twenty-two heads. Of these time will permit us to mention briefly only the most important, among which are the following:

One group claimed that the physician

is negative, telling patients only what not to do, while the osteopath, or chiropractor, does something concrete for them, producing a better mental reaction.

Others said the physician has too much of a graft, that he often merely looks at a patient once, and then charges \$5.00 for a prescription, which he "gets out of a book."

Some claimed that the doctors resent questions, and when questioned, a doctor either shuts up like a clam, or overwhelms the patient with an incomprehensible answer. (We might say in passing, that while we may be able to give people an answer, we cannot give them understanding.)

They also said that doctors are pompous, and claim to be wiser and less fallible than ordinary mortals.

Another group claimed that medical men criticized healing methods of which they have no definite knowledge; (?) that they condemn them on general principles, without inquiring into them, or studying them, or ever having seen a treatment.

A large group said that some of the cults draw upon supernatural powers, while doctors make use of human and mechanical forces only. (And there is no answer to this.)

They also said that doctors are narrow and biased, and that they would not admit any good in anything, outside of their own profession.

Still others claimed that successful medical men used the same treatment, in part, that is used by the cults, such as rest, diet, massage, etc. (We interject here that this procedure was plagiarized from the doctor and not by him), letting nature effect the cure, but that the doctors drag the treatment out longer, make it more expensive, and are deceptive about it.

It was claimed by certain others that physicians are not consistent in their ethical practices. If a doctor goes after business by the business method of advertising, he is likely to be forced out of his society. But if a doctor successfully treats a prominent patient, and is fortunate enough to know the editor of an influential paper, the case is written up conspicuously, and the doctor becomes, almost at once, a popular, high priced specialist.

Another group claimed that the doctor's attitude toward one another is about

as friendly as that of two strange bull dogs; and if one physician be dismissed from a case and another called in, the latter will inspect the patient pityingly, shudder with horror, as he examines the medicine left by his predecessor, and probably remark: "You did well to send for me. In another hour you would have been a goner; but I shall cure you!"

Others do not understand the ethical ideals of physicians. They claimed that an honest doctor will shield a crook, and that if a medical man blunders disastrously on a case, no one in the profession will do anything to prevent him from doing the same thing on other cases.

Another group claimed that doctors are always opposed to progress, and fight social legislation, like the Sheppard-Towner Bill, while the news in the public press shows that they are nearly always actuated by selfish and financial motives.

It was claimed, again, that doctors are responsible for the great army of drug addicts, now claiming public attention, and it is dangerous to take drugs for any illness, so that drugless healers are safer. (And I might add that it would be safer still, not to be sick.)

Still another group claimed that there are too many specialists among doctors, and that patients are handed around from one to another, making treatment very inconvenient, as well as expensive.

Others said that there is no way of telling the good from the bad doctor, and that it was too dangerous to experiment with them. Osteopathy, or one of the other systems, at least, could not harm patients, and has often cured them.

Now isn't that some arraignment, in the court of public opinion? Remember that these are the collective criticisms of nearly 6,000 people. To be sure, they cannot be justly applied to the medical profession in general, yet certain isolated grains of truth are scattered through them, sufficiently frequent to impress the unsophisticated mind and to warrant our taking cognizance of our shortcomings, and sincerely endeavoring to correct our faults.

But, supposing the impressions of these people are all wrong. Their statements represent their beliefs, and it is on their beliefs that they act. The result, then, so far as their relations to the medical profession go, is the same as if their impressions were correct. Their lack of confidence in physicians is thus explained,

and their patronage of the cultists, who promise everything, and advertise widely, naturally follows.

Under these conditions, the question naturally arises, what can we, as medical men, do to disabuse the public of its erroneous impressions, and show them the truth about the profession? Obviously, advertising in the lay press, after the manner of the quacks, would put us in an entirely false light, and place us on an equal footing with the very charlatans whom we would expose.

The only solution of the problem, it seems to me, lies in the education of the public through the various agencies at our command, such as organized propaganda, lecture campaigns, etc. The medical profession must be popularized by men who can write in clear, simple English, on medical subjects, for non-medical readers. The patient must be taken into the confidence of the physician. The difficult problems of medicine, as well as the efforts being made to solve them, must be explained. If the confidence of the public can once be established and the medical profession understood, the cults will fade away like mist before the sun.

It is interesting to note in this connection, that an organization of the leading papers of the United States has made arrangements with the Journal of the American Medical Association to obtain articles for publication, on medical subjects. These newspapers may also request the Association's advice and help in the presentation of this matter, in order that the public may not be further misled. In this way about seventy newspapers, with a circulation of 15,000,000 copies, more or less, may daily receive information in the possession of the American Medical Association, which is thus in a position to guarantee the accuracy of the news published, as well as to pass judgment on its medical value to the public.

Nevertheless, we must remember that however effective such education may ultimately become, it is hardly to be hoped that quackery can be entirely eliminated. It has been estimated that 10% of the public enjoys being humbugged. This group will insist on investing its money in wildcat schemes, on embracing every new "ism" that comes along, and on going to every new cult for treatment, when feeling "out of sorts." For this group there is evidently no hope, so

far as effective enlightenment in matters of health is concerned.

The other nine-tenths of the public are open to conviction. They can be shown that it is for their best interest to entrust their health and lives to the trained, scientific men of the medical profession, rather than to remodeled plumbers, chauffeurs, policemen and salesmen.

As already intimated, the responsibility for present conditions rests largely on the medical profession. They have neglected the minor ills of humanity. They have neglected to relieve the bachaches, headaches and other small discomforts from which people suffer, although they have brought under control the terrible scourges of the race, which in ages past have, at times, decimated the population. Here, then, is one reason for the existence and prosperity of the cults, in my opinion. They surely could not exist, if there were not a demand, albeit inspired by propaganda, for their services. People would not flock to their offices and pay good money, if they did not believe that they could get better service than they could at the hands of medical men. The physician is certainly more competent to treat the minor ailments of the public than the quack, and it is up to him to make good, if he would re-establish his former prestige. If our methods are indeed wrong, or inadequate, we should welcome a change to broaden (or narrow) them, and continue the use of every scientific agency that is effective. If our numbers are not sufficient to properly care for the minor, as well as the major afflictions of the public, should not our medical schools be increased in number and efficiency, until they can furnish an adequate supply of well trained physicians to meet all demands upon whatever basis these demands are made?

Permit me to mention, briefly, a personal experience. A few days ago, on meeting an intelligent man of another profession, whose family has for years been attended by several members of this association, he said, in a bantering way, "It is lucky you have made a specialty of surgery, instead of medicine." I naturally asked, "Why?" "Because, the chiropractors and osteopaths are putting the medical men out of business," he answered. "Oh, you have been reading the ads of some of those quacks," I said. "I am not referring to those fellows," he replied, "don't you know that there are chiroprac-

tors and osteopaths who are doing their work as conscientiously as you medical men, and curing cases that have been given up as hopeless by members of your profession?" I professed ignorance on the subject, and then he mentioned several cases. (Cites cases.)

Each of you have undoubtedly become familiar with similar cases. While we cannot scientifically account for the results claimed in these cases, we may not, in justice, deny that the various cults are convincing their patients. Would it not then be the part of wisdom for us to ascertain, if possible, the more effective factors in the successful treatment, rather than to ignore or ridicule the matter?

Gentlemen, I am not grinding the axes of the chiropractors, osteopaths, or any of the cults, nor have I been knocking the medical profession. Between our profession and the various systems of healing, there is, in my opinion, no comparison, either in preparatory training or scientific attainment. I have only tried to show that in my humble opinion the greatest and noblest of the professions is not awake to its opportunities, along certain lines, but is still toiling along in the ruts of mediaeval conservatism.

County Medical Societies' Reports

CUMBERLAND COUNTY.

Elston S. Corson, M.D., Reporter.

The Cumberland County Society meet at the Weatherby House, Millville, on April 8th. Dr. Percy C. Lummis, president, in the chair.

Dr. W. L. Cornwell, treasurer, reported a good balance in the treasury. Dr. E. S. Corson, chairman of the Special Welfare Committee, reported his visit to Trenton and complimented the State Committee on its able defense of the title "Doctor" that it should always be qualified by adding the special branch of practice in which it was used, e.g., Doctor-Chiropractor, etc.

Dr. John C. Hirst of the University of Pennsylvania, gave an illustrated address on "Caesarian Operations." He prefaced his remarks on the use of pituitrin. He said that no more than three minims should be used at one time and only one strength should be dispensed. From one to six thousand fatalities result from ruptured uterus. Syphilitic patients should never be given the drug unless hospital facilities are at hand. The diagnosis of early pregnancy is difficult especially in fat women. The sugar test up to the 12th week has proven unsatisfactory. In from 3 to 5 per cent of women sugar in the form of lactose is found in the urine. This does not invalidate the test. Take four ounces of granulated sugar to two glasses of water, acidulated with lemon juice. Take one glass followed two

hours later by the balance; if pregnancy exists sugar will appear in the urine.

A quick and fairly accurate way to determine the viability of the child is to push the head down in the superior strait if the protruberance can be felt above the abdominal pubes there is a dystocia and section should be considered as the operation of choice. A good method to induce labor consists in giving two ounces of castor oil and ten grains of quinine twenty minutes later, followed by three minims of pituitrin. If labor begins don't give more than two or three doses.

Before section give mixture of 1 c.c. pituitrin and 2 c.c. of aseptic ergot. Of this one-third c.c. at a dose. This seems to lessen the chances for infection.

ESSEX COUNTY.

Alfred Stahl, M.D., Reporter.

The Essex County Medical Society met in Newark on March 13th and heard an unusually interesting address enlightened by a rarely excellent demonstration of success in treating visceroptosis. Royal Storrs Haynes, M.D., of New York, spoke on "The Mechanics of the Tired Child," and the demonstration was by a little girl patient of his who showed wonderfully the power of trained muscles to correct at will faulty posture of pelvis, back, shoulder girdle, neck and limbs. A report was presented of the status of medical legislation at the close of the Legislature session at Trenton.

HUDSON COUNTY.

William Freile, M.D., F.A.C.S., Reporter.

The regular monthly meeting was held on April 1, 1924, in the auditorium of the Nurses' Home, City Hospital.

The unusual inclemency of the weather attenuated the attendance. The absentees missed a most instructive talk by Dr. Glentworth Reeve Butler, who took for his subject "Practical Classification of Cardiac Disease and Clinical Significance of Murmurs and Arrhythmia."

(We hope to publish a resume of this interesting talk in an early issue).

Dr. S. A. Cosgrove, chairman of the Building Committee, presented a comprehensive report. On vote it was ordered printed in the "Bulletin," and have it come up for discussion at the next meeting.

PASSAIC COUNTY.

Louis G. Shapiro, M.D., Reporter.

The April meeting of the Passaic County Medical Society was held in the Chamber of Commerce Rooms, Paterson, on Thursday evening, April 10th. Dr. John N. Ryan presided. Thirty-two members were present.

Dr. George L. Brodhead of New York read a paper on "Dry Labor—a Study of 182 Cases from Private Practice," after which a general discussion on the management of abnormal labor followed.

Dr. Henry H. Lucas was elected member for Passaic County on the Nominating Committee of the State Society and Dr. John S. Yates was elected alternate member.

The president, on behalf of the State Rehabilitation Clinic, impressed on the society that it is unnecessary for injured employees to engage counsel in appearing before the compensation court, that the injured employee

obtains full justice without the cost of legal aid.

Dr. J. C. McCoy on behalf of the Paterson Board of Health extended our society the courtesy of the assembly hall in the new Board of Health Building, for our meetings. The society accepted the offer and extended a vote of thanks to the Board of Health.

SALEM COUNTY.

William H. James, M.D., Reporter.

The regular monthly meeting of the Salem County Medical Society was held April 9th, at the Memorial Hospital, Salem, N. J., Dr. Franklin H. Church in the chair. After the regular business was transacted the society had the pleasure of hearing the essayist, Dr. D. B. Pfeiffer of Philadelphia, who selected for his subject, "Present Day Aspects of Upper abdominal Diseases."

The doctor spoke principally on the symptoms, treatment, etc. of gastric and duodenal ulcers. After the paper was discussed by a number of the physicians present, the doctor was given a rising vote of thanks for his most interesting paper. The following members and invited guests were present:

Drs. C. M. Sherron, M. L. Ewen, R. M. A. Davis, David W. Green, W. T. Hilliard, John F. Smith, and Franklin H. Church of Salem; Dr. E. E. De Grofft of Norristown; Dr. Davies of Elmer; Drs. W. P. Glendon and John Moore of Bridgeton; Dr. Wilson Stout of Newark; Dr. Downs of Swedesboro; Dr. Lynch of Carney's Point; Dr. Wm. H. James of Pennsville, and Dr. John M. Summervill of Pennsgrove.

The next meeting will be held at the Salem County Club, May 15th, which will be a social session. The doctors with their wives and sweethearts will be present to enjoy a planked shad dinner.

SOMERSET COUNTY.

Dan S. Renner, M.D., Reporter.

The regular April meeting of the Somerset County Medical Society was held in the Court House, Somerville, April 10, 1924.

Dr. Edward S. Hawke, counselor for the third district, made an official visit. He was accompanied by Ex-President of the State Medical Society, Dr. H. B. Costill. Both of these gentlemen gave short, but very instructive talks.

After the routine business was completed, Dr. David F. Weeks gave a thorough discourse on the cause, symptoms, diagnosis and treatment of diabetes mellitus from the general practitioner's standpoint. This talk was followed by a general discussion.

UNION COUNTY.

Russell A. Shirrefs, M.D., Reporter.

The Union County Medical Society met on the evening of April 9th at the Elks' Club in Elizabeth, with an attendance of about sixty members. Drs. Hoover, Ward and Williams, who have recently located in the city, were invited to sit with the society and take part in the discussions. Dr. Roderick Byington of Summit was elected to membership, having transferred from the Kings County Society. Three other applications were referred to the membership committee for consideration. Dr. Schlichter, for the legislative committee, re-

ported that 29 of our members answered the call of the Welfare Committee by going to Trenton on March 3rd and attending the legislative hearing on the several bills under medical sponsorship.

Following the routine business, a symposium on cancer was presented, Dr. A. R. Casilli speaking of its pathological aspects; Dr. J. S. Green, cancer of the breast; Dr. M. A. Shangle, stomach cancer; Dr. N. L. Wilson, cancer of the nose and throat; Dr. Jos. Funk, uterine cancer; Dr. I. Lerman, cancer of the genitourinary tract; Dr. S. T. Quinn, the therapeutic action of radium, and Dr. F. Steinke, the after treatment of cancer by the x-ray.

Local Societies' Reports

Atlantic City Hospital Staff Report*

By Joseph H. Marcus, M.D.,

Case No. 1.—Dorothy D. 9 months of age, full term, after a normal labor, and weighed 7 lbs. at birth. There was an indefinite history of T. B. in the father. Baby was on the breast for 2 weeks, and then put on a peptogenic milk formula. On this food for a few months, and then changed to Mellin's food, with milk and water, in the preparation of which formula the milk and water were boiled for ten minutes, as the baby was having diarrhoea. She had been taking this food for about 4 months, and gained steadily in weight. About a week ago, she feel out of a low chair, bruising her forehead, but did not seem hurt. Beginning the next day she cried a great deal during her bath, and a few days later it was noticed that motions of the legs caused pain. She lay on her back and kept her legs drawn up, and began to cry when anyone approached her. Her appetite had fallen off, and had lost color and weight, since the appearance of the symptoms, although she showed no signs of indigestion. No temperature and the urine did not stain the diapers. Baby was brought to the dispensary, with the chief complaint of "pain in the legs and inability to move the elgs, and loss in weight." Physical examination: Fairly well developed and nourished, and moderately pale. She was afraid of being touched. The fontanelle was level, and there was an ecchymosis on the right side of the forehead. The 2 lower central incisors had erupted, and the gum was normal about them. The upper gum was distended by the 4 incisors, and the gum was a little purplish over them. Tongue was clean and throat normal. There was a slight rosary. Heart, lungs and abdomen abnormal. Liver was palpable. 2 cm. below the costal border in the nipple line; spleen was not palpable. Spine perfectly flexible. She preferred to lie on her back with the legs flexed at the hips and knees. Neither active nor passive motions were limited, but motions of hips and knees caused much pain. There was no definite tenderness and no swelling about the bones or joints. The arms were not tender and were used freely without discomfort. The knee jerks were equal and normal Kernig's sign was absent, sensation to touch and pain

were normal. There was no enlargement of the peripheral lymph nodes. Temperature normal.

Diagnosis.—Tuberculosis of the spine or hip-joints was considered on account of the exposure to T. B. The normal mobility of the spine and at the hips, together with the normal temperature rule this out. The mother thought that the fall might be the cause of the pain; the baby had, however, stopped creeping before the fall, and showed no evidence of injury at the time. It is hard to conceive, moreover, of an injury that would involve both legs, and not show any physical signs. Infantile paralysis and multiple neuritis might be thought of on account of the pain. Infantile paralysis can be at once excluded because of the absence of paralysis and the presence of normal reflexes after 3 weeks. Multiple neuritis can be ruled out because at this age it is almost always a sequela of diphtheria, and consequently, is seldom accompanied by pain. The reflexes are intact, and there is no paralysis, or disturbance of sensation. Osteomyelitis and periosteitis seldom occur in more than one place at a time and can be excluded on the good general condition and the absence of fever and localized tenderness. The combination of pain without physical signs is characteristic of rheumatism in early life. Rheumatism almost never occurs in early infancy, however, and will not account for the swollen and purplish gum. The slow onset, the unwillingness to use the legs, the pain on motion, and the position in which the legs are held are almost pathognomonic of scurvy, and justify the diagnosis without any other evidence. The combination of these signs with the swollen purplish gums, another characteristic sign of scurvy, cannot be accounted for in any way and make the diagnosis absolute. The ecchymosis on the forehead may be a scorbutic manifestation, but on the other hand, may be simply the result of the fall. The prolonged use of the boiled milk, together with the absence of all other foods is corroborative evidence of the diagnosis of scurvy, as it is undoubtedly one of the causes of this disease. The prognosis is absolutely good. She will be perfectly well in a week if properly treated.

Treatment.—The first step is to remove the probable cause of the disease, that is the boiling of the milk. Remove the Mellin's Food, and substitute milk sugar, and add starch in the form of barley water, to hinder the formation of large tough curds. This can also be accomplished by the addition of sodium citrate, or lime water in the proper proportion, instead of the barley water. The sugar should be mixed with the hot barley water, and the mixture cooled before the milk is added. Fruit juices have a specific action on infantile scurvy, and should therefore always be given. They will cure the process even if the cause is not removed. Orange juice is the best, because it is the most readily taken. Babies seldom do object to it. It may be given plain or diluted with water. Speak of the Phila. Pediatric idea of the ineffacy of orange juice at times, especially in September and October, when the administration was not useful. Summer type of oranges given with scalded water, with a pinch of soda bicarb. No objection to cane sugar if the orange is

*Read at staff meeting, Atlantic City Hospital.

sour. May be given all at one dose or divided in 2 doses. Best given one hour before a feeding, when the stomach is empty or near empty. One ounce is the proper dose. Less than this may be ineffectual and more is unnecessary. Substitutes are tomato juice, and given in twice the dose as orange juice; grape juice or potato juice.

Case No. 2.—Samuel D., 4½ years of age. History unobtainable due to the absence of the mother, but apparently is the child of healthy, normal parents, and has always been well. There are 4 other children. He has never ceased to wet the bed, although he had not wet his pants since he had been wearing them. Usually wet the bed soon after going to sleep and again early in the morning. Slept very heavily. Removal of adenoids and circumcision had not diminished the frequency of bed-wetting. Appetite and digestion were good, and his bowels moved regularly. No pin worms had ever been seen, and he was not especially nervous.

Physical Examination.—He was well developed and nourished and of good color. He seemed of normal intelligence, and did not at all appear neurotic. Tongue clean; teeth good, throat normal. Heart, lungs and abdomen normal. Liver and spleen not palable. No irritation of the penis, and no irritation about the anus. Extremities normal, no spasm or paralysis, knee jerks, cremasteric and abdominal reflexes normal; no enlargement of the peripheral lymph nodes. Urine strongly acid and specific gravity of 1,030, otherwise normal.

Diagnosis.—The diagnosis is of course nocturnal enuresis; it is moreover, undoubtedly, not organic in origin, but of the so-called functional or essential in type. There are no evidences of inflammation or irritation of the rectum, penis, urethra or bladder. The only possible reflex cause is then, the highly acid and concentrated urine. It is probable, however, that this is merely a temporary condition and not the real cause of the trouble. Neither he nor his parents are neurotic, his general condition is good, and he is not anemic. Increased irritability of the spinal centres cannot therefore be the cause. It must be, then, interference with the normal cerebral control of the spinal centres. This interference cannot be due to the adenoids, as they have been removed. It is in all likelihood, the result of a combination of somewhat tardy development of the cerebral centres and the depressing influence of the very deep sleep on their action.

Prognosis.—He is certain to get over it, because as time passes the cerebral centres will develop and control the spinal centres, even during sleep. It is impossible to know how long it will be before this happens, probably however, not under a year. Careful treatment will presumably relieve the condition to a certain extent, and perhaps hasten recovery.

Treatment.—The patient cannot help wetting the bed when he is asleep. Not being responsible he ought not to be punished for it. Appeals to his pride or rewards may be of some assistance, but probably will not. He should be given water freely to diminish the concentration of the urine, and citrate of potash in doses large enough to make the re-

action of the urine alkaline. 15 grains 3 or 4 times a day will probably be sufficient to do this. The water must all be given before 4 P. M. because if given later than this, it will increase the tendency to wet the bed by filling up the bladder. He should for the same reason have a dry supper, and the avoidance of sweets during the day. He should pass water just before going to bed and should be awakened early in the evening to pass it again. He should also be made to pass it when his parents go to bed, and as soon as he begins to wake up in the morning. Sometimes the use of an alarm clock is beneficial in awakening the patient at night. Sleep on a hard bed, and the coverings carefully regulated. If he is too warm, he will sleep more soundly, and be more likely to wet the bed; while if he is cold, he will secrete more urine and also wet the bed. It will be well to raise the foot of the bed about 6 inches, as this tends to take the pressure of the urine off of the sensitive neck of the bladder. It is advisable to give exercises to train him to control his bladder. He should be made to pass water every 10 or 15 minutes for an hour at some time during the day, and at another should be made to hold his water as long as possible. Belladonna is indicated in this instance because of its action in diminishing reflex excitability. He should be given 5 drops of the tr. after supper. The dose should be increased one drop each night, until toxic symptoms appear. It should then be diminished 2 drops, and kept at this dose for some months. He is in good condition, and shows no signs of nervous irritability, therefore tonics and nerve stimulants are not indicated. Thyroid may be given a trial.

(We will insert Case No. 3, and also a report of the Jersey City Hospital Staff meeting in next month's Journal.—Editor.)

Associated Physicians of Montclair and Vicinity.

Alfred Stahl, M.D., Essex Co. Reporter.

The regular monthly scientific meeting of the Associated Physicians of Montclair and Vicinity was held in Montclair Club Hall on Monday evening, March 24, 1924.

Dr. Alfred Stengel, Professor of Medicine in the University of Pennsylvania was the speaker of the evening. Prof. Stengel gave us one of the most interesting addresses of the year on the subject "Cardio-Vascular Disease." It was different from the usual address on that subject in that the more common and better understood conditions were enumerated and dismissed and the less common, though none the less important conditions, were discussed in detail. The Professor divided his subject into: (1) Valvular disease; (2) Myocardial disease; (3) Functional disease and (4) Peripheral disease. The first two divisions were touched lightly, while the latter two divisions were discussed at length.

Attention was called to the fact that we should not consider the system as a pump and a piping system because blood pressure is also dependent on other factors. Blood leaving the heart under a pressure of 150 millimeters of mercury reaches the peripheral vessels at a pressure approximately of 120 m. m. and in passing through the capillaries into the venous circulation the pressure drops to

about 15 m. m. Were it not for the exercise of muscle groups in the trunk and extremities continually pressing the blood onward and for the force of gravity sending it downward from the brain the venous blood would never get back to the heart. Numerous cases of cardiac decompensation are due, said the doctor, to failure of sufficient blood being returned to the heart. Large varicose veins, or individuals with pendulous abdomens and over developed and enlarged portal circulation he gave as examples of where the heart pumped blood into veritable lakes and consequently without help the blood would be returned to the heart in insufficient quantities with concurrent development of cardiac failure. Thus the doctor concluded that over-eating was potentially the largest contributor to a great many cases of cardiac failure in individuals where no real myocardial disease existed.

Dr. Stengel spoke of the fact that leucic aortitis and aortic insufficiency of leucic origin occurred between the ages of 40 and 45 and that aortic insufficiency under 30 was almost without exception due to rheumatic infection. Neuro-circulatory asthenia or "Effort Syndrome" was discussed at some length. This condition of cold and blue extremities with rapid heart is prevalent now as well as during the war and was indeed described many years ago said the doctor. It is probably associated with, or a precursor of, organic cardiac disease.

General discussion followed the address and was closed by Dr. Stengel. A rising vote of thanks was given the doctor.

Colonel Keefer, Chief Surgeon of the Second Corps Area, with headquarters at Governor's Island, then spoke a very few minutes on the policy of the War Department and its desire to establish skeleton hospital units throughout the country so that in time of need some organization might be in existence. Dr. Keefer expressed hope that Mountinside Hospital might decide to request the War Department for permission to co-operate in the formation of a hospital unit here.

Middlesex County Tuberculosis League.

The annual luncheon of this League was held at the New Packer House, Perth Amboy, April 24th, Dr. Charles I. Silk presiding. Dr. Edgar T. Shields of the National Association spoke on "County Clinic and Nursing Work."

Unusual Clinics For Industrial Physicians.

Measures which industry and science are pushing to safeguard health and reduce accidents in the factories of the nation were explained by speakers at the tenth anniversary meeting of the Conference Board of Physicians in Industry which convened last month at the Hotel Astor, New York.

The organization which acts as medical adviser to the National Industrial Conference Board, which includes in its membership Dr. J. B. Harvey of the Tidewater Oil Company of Bayonne, N. J., and Dr. W. E. Ramsay of the Raritan Copper Works at Perth Amboy, N. J.

Among the speakers were Samuel Gompers, president of the American Federation of Labor; Dr. W. H. Park, president of the American Public Health Association, and Surgeon

General H. S. Cummings of the United States Public Health Service.

What is believed to be the first series of clinical demonstrations of their kind to a group of physicians specializing in industrial practice were given on Saturday as part of the convention program at the clinical amphitheater of the Post-Graduate Medical School. The entire day was devoted to surgical x-ray, treatment and clinical demonstrations as well as the unusual types of factory accidents and industrial illness.

INTERNATIONAL CLINIC TOUR.

Inter-state Post-Graduate Clinic Tour to Canada, British Isles and Paris in 1925, is now being arranged under the supervision of the managing-director's office of the Tri-State District Medical Association. The time for leaving will be about the middle of May. The tour will consume, approximately, two months' time and the total cost from Chicago and back to Chicago again will be less than \$1,000.00. This will include all clinic arrangements and admissions and all traveling expenses, except meals on Pullmans in America and tips on ocean steamer. First-class hotels will be used everywhere, and the ocean passage will be on the largest and finest of the new one-cabin ships. Clinics are being arranged in Dublin, Belfast, Liverpool, Manchester, Leeds, Edinburgh, Glasgow, Newcastle, London and Paris and other points of clinical interest. The clinics will be conducted by the leading clinicians of these cities. The opportunity will be given, subsequently, to visit the clinic centers in other parts of Europe.

This tour is open to members of the profession who are in good standing in their State or provincial societies and their families and friends. Sight-seeing programs will be arranged, practically, every day abroad, including the most scenic part of the countries visited, without extra cost. On account of the great demand for reservations, applications should be made as early as possible to Dr. William B. Peck, managing-director, Freeport, Illinois.

Academy of Medicine, Northern New Jersey.

Stated Meeting, May 21, 8.45 P. M. Paper: "Maternal Welfare," by Dr. G. W. Kosmak of the Lying-In Hospital, N. Y.

Section on Eye, Ear, Nose and Throat, May 12th, 8.45 P. M. Report of Cases. Paper by Dr. J. E. McKenty on "Observations on Laryngeal Cancer," with lantern slides. Discussion by Drs. N. L. Wilson, H. C. Barkhorn and E. A. Ill.

Section on Medicine and Pediatrics, May 13, 8.45 P. M. Paper by Dr. P. W. Nathan of New York on "Arthritis and Its Supportive Treatment" and discussion by Drs. C. R. Keppler, H. C. Barkhorn, Theo. Teimer and J. E. H. Guthrie, D.D.S.

Section on Surgery, Obstetrics and Gynecology, May 27th, 8.45 P. M. Report of Cases. Paper on "Treatment of Intra-Capsular Fractures of the Femur in the Aged," by Dr. John K. Adams. Meetings held at 91 Lincoln Park.

**DO NOT FAIL TO ATTEND YOUR
COUNTY SOCIETY'S MEETINGS**

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

CHAS. D. BENNETT, M. D., Chm., 750 Broad Street, Newark.

EDITOR:

DAVID C. ENGLISH, M.D.,
P. O. Box 83, New Brunswick

ASSOCIATE EDITORS:

CHRISTOPHER C. BELING, M.D., Newark
HENRY B. COSTILL, M.D., Trenton
JAMES HUNTER, JR., M.D., Westville
HARRISON S. MARTLAND, M.D., Newark
FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

ONE HUNDRED AND FIFTY-EIGHTH

Annual Meeting of the

Medical Society of New Jersey

will be held in

HADDON HALL, ATLANTIC CITY

June 5, 6, 7, 1924.

ANNOUNCEMENTS.

The Committee on Credentials will meet at Haddon Hall, on Wednesday afternoon and on Thursday morning, and its office will be open at appointed times during the meeting. The Constitution requires that all fellows, officers, annual and permanent delegates, and reporters shall register with this committee.

Permanent delegates failing to register will be marked as absent by the Recording Secretary. Annual delegates must present to this committee a certificate of election signed by the president and secretary of their component society. Without such cer-

tificate they cannot sit as member of the House of Delegates.

Every permanent delegate must present a certificate bearing the seal of the society and signed by the Recording Secretary, and without such certificate he cannot register, nor vote in the House of Delegates. Nominees for permanent delegates cannot register as permanent delegates until after their election by the Society, when they will receive certificates from the Secretary so that they can obtain their appropriate badges.

All members of component societies who are in good standing are entitled to sit as associate members and have the privilege of discussing papers in the general session, but have no vote nor right to take part in the discussions of the House of Delegates.

The rates at Haddon Hall, on the American plan, are: Rooms with running water, 1 person, \$6.00 to \$8.00 per day; 2 persons, \$12.00 to 14.00 per day. Rooms with bath: 1 person, \$10.00 per day; 2 persons, \$14.00 to \$20.00 per day. If you have not already engaged a room, it would be wise to do so at once.

Exhibits of instruments, books, pharmaceutical preparations, x-ray apparatus, etc., will be shown in the Ground Floor Exchange of the hotel and members are urged to avail themselves of this opportunity to examine the very latest improvements in these various departments.

All papers read before the Society or appearing by title on the program, whether read or not, thereby become the property of the Society. The author of each paper is required to give to the Recording Secretary a legible copy of the same BEFORE reading. The expense of alterations in a paper after it is in type, and the cost of illustrations, is borne by the author.

Excepting orations and the address of the President, the time to be occupied in the actual reading of a paper is limited absolutely to twenty minutes. Those opening the discussion are allowed ten minutes each; others five minutes each.

Certificates of Nominees for permanent delegates must follow the special form given in the Constitution on page 12. They should be sent to the Recording Secretary at least one week before the meeting, so that the names may be presented to the Society for election.

Members desiring to present voluntary papers on reports of cases should first have their papers accepted by the Committee on Scientific Work and then apply to the Committee on Program for a position.

Papers and reports not presented when called for by the President cannot be presented at a later time unless the regular order of business is completed.

All sessions will be opened promptly at the hour set in order that the program may be carried out as planned.

The Board of Trustees will meet at Haddon Hall, Wednesday, June 4th, 8 P. M.

DAILY PROGRAM.

Thursday, June 5th, 1924, 10 A. M.

MEETING OF THE HOUSE OF DELEGATES.

Speakers must announce their names. No member may speak a second time in any discussion.

Call to order—Invocation.

Address of Welcome, Hon. Edward L. Bader, Mayor, Atlantic City.

Fraternal Greetings, The President of the Atlantic County Medical Society.

Report of Committee on Credentials, W. J. Carrington, Chairman.

Reading of Minutes of the 1923 Meeting.

Report of Permanent Delegates.

Nominees for Permanent Delegates.

Election of Permanent Delegates.

Report of Committee on Arrangements and Programs, M. W. Reddan, Chairman.

Report of Committee on Scientific Work, Franklin J. Kellar, Chairman.

Report of the Committee on Publication, Charles D. Bennett, Chairman.

Report of the Corresponding Secretary.

Report of the Recording Secretary.

Report of Board of Trustees.

Report of the Judicial Council.

Report of the Committee on Honorary Membership, Walter B. Johnson, Chm.

Report of the Treasurer.

Report of Committee on Prize Essay, Alexander Marcy, Jr., Chairman.

Report of Committee on Public Hygiene and Sanitation, Gordon K. Dickinson, Chairman.

Report of Committee on Health Problems in Education, Harry W. Haight, Chm.

Report of the Delegates to the American Medical Association and to State Societies.

Report of Special Committees.

Each member of the Nominating Committee should present to the Recording Secretary his certificate before the opening of the afternoon session, so that the names of the Nominating Committee may be announced as indicated on the program. The Nominating Committee will meet at 5.30 P. M. in the committee room.

Thursday, June 5th, 2.30 P. M.

MEETING OF THE HOUSE OF DELEGATES.

Unfinished business.

Report of Business Committee.

Miscellaneous business.

GENERAL SESSION.

Reading of the names of the Nominating Committee.

2. THE PALLIATIVE TREATMENT OF CANCER OF THE UTERUS AND CANCER OF THE BREAST,

Edgar A. Ill, Newark, N. J.

Abstract of paper and names of those to open the discussion will appear in the Official Program.

Thursday, June 5th, 1924, 8.30 P. M.

Surprise Social Program in Vernon Room, Haddon Hall. Details to be announced later.

Friday, June 6th, 9 A. M.

MEETING OF THE HOUSE OF DELEGATES.

Unfinished business.

Report of the Business Committee.

New business.

GENERAL SESSION.

3. ROENTGEN-RAY THERAPY IN HEMORRHAGIC METROPATHIES AND UTERINE MYOMATA,

J. Roemer, Paterson, N. J.

Abstract.—Temporary castration by means of the Roentgen-Ray in the treatment of Metrorrhagia, Menorrhagia and Dysmenorrhea in young girls and women. Permanent castration in the treatment of Uterine Hemorrhage in women of forty years and over. Temporary and permanent castration in the treatment of Uterine Fibroids. Indications and contra-indications for Roentgen-Ray castration.

Discussion—(To be announced at meeting.)

4. MANUEL ARTIFICIAL RESPIRATION FOR RESUSCITATION; ITS INDISPENSABLE IMPORTANCE,

Frank W. Pinneo, Newark, N. J.

Discussion by Dr. H. W. Haggard of Yale Physiological Laboratory and Dr. Daniel Stock.

Note.—In Room A—demonstrations will be given before and after each session of the Convention, of Manuel Resuscitation, as described in Dr. Pinneo's paper.

5. ORATION IN MEDICINE,

E. J. G. Beardsley, Philadelphia, Pa.

Friday, June 6th, 1924, 2.30 P. M.

MEETING OF THE HOUSE OF DELEGATES.

Report of Nominating Committee.

Election of Officers.

Unfinished business.

Report of Business Committee.

Miscellaneous business.

See Dr. Eagleton's Editorial, page 168.

GENERAL SESSION.

6. THE MODERN TREATMENT OF DIABETES,
Martin J. Synnott, Montclair, N. J.

Abstract.—General management of cases. Normal dietary requirements. Usual maintenance diet for the Diabetic. Indications for Insulin and Insulin dosage. Hypoglycemic shock. Lantern slides. Discussion by Theodor Teimer, Newark, and James W. Sherrill, Morristown.

7. TREATMENT OF PULMONARY TUBERCULOSIS BY ARTIFICIAL PNEUMOTHORAX,
M. J. Fine, Newark, N. J.

Abstract.—A resume' of the indications for, and a discussion of its practicability, based upon the employment of the procedure in over one hundred cases of Pulmonary Tuberculosis.

Discussion (to be announced at time of meeting).

8. "ENFORCING THE MEDICAL PRACTICE ACT."

Address by George H. Whiteside,
Counselor, New York City.

Friday, June 6th, 9 P. M.

Formal Dance, beginning at 9 P. M.—
Vernon Room.

Buffet Supper will be served at 10.30 P. M., at which time the President's Address and Report of the Welfare Committee will be given by President Wells P. Eagleton.

Dancing to be resumed after Dr. Eagleton's address.

Saturday, June 7th, 9.30 A. M.

HOUSE OF DELEGATES.

Miscellaneous business.

GENERAL SESSION at 10 A. M.

9. PAPER by Max Danzis, Newark, N. J.

The Title and Abstract of this paper will be given in the Official Program.

Discussion.—Drs. John F. Hagerty, C. M. Robbins and B. H. Greenfield.

10. FOOD COMBINATIONS—AN ORIGINAL SCHEME OF EATING BASED UPON THE NEWER KNOWLEDGE OF NUTRITION AND DIGESTION,

N. Philip Norman, New York.

Abstract.—Introduction....relation of health and disease to diet, the deficiency diseases....the bread, meat and potato type of diet, its deficiencies and results....balanced meals and their shortcomings, their similarity to the bread, meat and potato type of mealsacid and alkali-forming foods and how they affect the digestive processes intestinal fermentations,....putrefactions and infections, author's scheme for offsetting the processes....the intestinal flora....its response to a corrective eating scheme....the scheme is economical and practical and supplies every essential element of nutrition....the educa-

tion of the patient of the value of corrective eating to offset digestive troubles and to remedy existant gastro-enteric diseases.

Discussion.—Martin J. Synnott, Montclair, N. J.; Vincent B. B. Lyon, Philadelphia, Pa.; Edmonde D. Neer, New York.

11. THE SUCCESS OF ORTHOPAEDIC PRACTICE LARGELY DEPENDENT UPON THE PROPER APPLICATION OF PHYSIOTHERAPY (illustrated).

Harold D. Corbusier, Plainfield, N. J.

Abstract.—Short synopsis of history of Physiotherapy and origin of the term. Previous to the World War very little in this direction was being done in the U. S. During the war the work came into prominence and since then up-to-date hospitals and clinics have instituted departments of Physiotherapy. The different modalities are now being utilized in both surgical and medical cases. There is still much misconception as to the application of the different modalities and what results can be expected.

Physiotherapy is an essential adjunct in the treatment of Orthopaedic cases; both before and after operation; also it is indispensable as a name of muscle training in its many phases; industrial surgery is most dependent upon physiotherapy methods. Discussion of various classes of cases treated with remarks as to results that can be expected.

Discussion.—Dr. R. Tait McKenzie and Dr. Frank B. Granger, Boston.

Saturday, June 7th, 2.30 P. M.

GENERAL SESSION.

12. ORATION IN SURGERY,

Joseph C. Bloodgood, Baltimore, Md.

13. PREOPERATIVE, OPERATIVE AND POST-OPERATIVE CARE OF THE PROSTATIC—(Lantern slide and motion picture demonstration)

Oswald S. Lowsley, New York.

Abstract.—This paper will deal with the modern treatment in all phases of enlargement of the prostate. The greatest advance since the beginning of surgery on this gland has been the realization that there must be a period of pre-operative treatment, this is summed in the word drainage.

The next great advance is the replacement of general anaesthetics with regional anaesthesia in operations upon the prostate.

A brief discussion of post-operative care.

Discussion.—J. F. Stock, Hoboken, N. J., and Samuel Robertson, Newark, N. J.

MEETING OF THE HOUSE OF DELEGATES.

Unfinished business.

Report of Business Committee.

Miscellaneous business.

ADJOURNMENT.

A more complete Program will be sent to our members about May 20th. Preserve it and if you attend the Annual Meeting bring it with you.

TO ALL THE MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY.

The annual meeting of the Medical Society of New Jersey will be held at Had-don Hall, Atlantic City, on Thursday, Friday and Saturday, June 5th, 6th and 7th. The Committee on Arrangements have gone to great trouble to prepare a most attractive program. The past three years have been of great importance to the Society. During the past year an effort has been made to place the Medical Profession in that position in public health and economic, industrial and educational affairs in relation to medical practice, which it alone is qualified by its training and ethical standards to occupy. Reports of the work will be discussed and future policies of the Society will be decided upon.

As President, I am asking all members of the profession to make an earnest effort to attend the meeting and bring their families with them, for they should be as much interested in the economic and ethical aspects of medicine as the physician himself. Too long has the profession surrendered privilege after privilege and advantage after advantage simply from inactivity and internal weakness. The time has come when every member must feel that he owes a certain amount of his time to the profession as a whole. I personally urge that every member let nothing interfere with his attendance at this meeting. Come and give those of the profession, who are working to add to its prestige and to increase its influence, the advantage of your council and help.

Wells P. Eagleton, President,
Medical Society of New Jersey.

EDITOR'S RESPONSIBILITY.

The Editor again calls attention to the fact that he is not responsible for any erroneous or questionable statements that are given in the Original Articles that appear in our Journal.

We have had our attention called to what are declared to be "Utterly Erroneous Statistics" given in a presidential address recently published in our Journal to the effect that drunkenness had greatly increased since the incoming of prohibition and citing Newark, Jersey City and New York City as furnishing evidence thereof.

A printed document has been sent to us which declares that the said statistics are utterly deceptive. Under headings: "Pub-

lic Drunkenness Tremendously Decreased"; "Enormous Decrease in Drunkenness in New York City," and "One Drunken Woman Under Prohibition to Ten Under License." The author of the document gives the following as one of the several items he cites: "Compared with the fiscal year ending September 30, 1914, the commitment to the county jails for drunkenness decreased 7,082, or about 52 per cent.; New York City institutions, 11,130, or about 70 per cent.; and penitentiaries, 4,748, or about 75 per cent. This is taken from the published reports of the Department of Correction of the City of New York, for the year ending June 30, 1923.

THE DOCTORS AND THE PUBLIC.

The Editor believes it would be wise for our members to consider, at the annual meeting, the question of the attitude of the public toward the medical profession, and if possible adopt some measure to improve existing conditions, or, after discussion, refer it to the Welfare Committee for action. How far are we as members of the profession responsible for the public's misunderstanding. The public needs to know that we are not in business to make money and gain prominence and power for our own private advantage. Our Society clearly indicated in its Constitution adopted 158 years ago the objects sought in its organization: "Mutual Encouragement"; "Advancement of the Profession" (in knowledge and efficiency), and the "Promotion of the Public Good." As far as fees were concerned, it is evident they did not regard it as a *business enterprise* to make money. They had the public's confidence and support. How far is the lack of that confidence and support today due to the actions of members of the profession—a small number of whom are inside and a far larger number outside the membership of our county societies. Such actions, for example, being: Misstatement of facts and statistics, as stated in the preceding editorial; entering the profession to make money rather than to render *service* as the primary motive; seeking other physicians' patients; speaking to patients of other physicians disparagingly; fee splitting; overdoing of specialism, e.g., entering practice as a specialist immediately after graduating from a medical college, instead of after five or ten years' practice as a general practitioner, as we believe it should be; serious disagreements of specialists, as in the Thaw case, four testifying that he is

insane and an equal number declaring him sane; members of a county society, who failed to attend a meeting of the Society, opposing the action taken by their society before a legislative committee, etc., etc.

We call special attention to the paper of Dr. Cutts on page 157, and to articles on pages 173-175, as having a bearing on these matters.

Dr. Charles D. Bennett, Chairman of our Publication Committee, has sold his house in Clinton Avenue and should hereafter have his mail addressed to him at 750 Broad Street, Newark (offices of the Mutual Benefit Life Insurance Co.) His residence for the present is in Summit, N. J. He will spend the month of July at Lake Kezar, Maine.

The New York State Journal of Medicine in speaking of receiving medical news from the various counties, says:

We are pleased with the plan adopted by the *Journal of the Medical Society of New Jersey*. That journal has an official reporter in each county medical society, and prints his name at the head of his contributions. The *Journal* uses several pages of local news which the reporters send each month.

We are sorry to say that we do not receive very much of the local news our *Journal* gives from the reporters, most of it is culled from the newspapers. We hope that hereafter we shall receive far more from the reporters.

We certainly should receive prompt notice of every death occurring of members of this society. Sometimes two or three months elapse before we hear of deaths that have occurred.

IDEAL COUNTY MEDICAL SOCIETY

The Idaho Falls Medical Society has all practicing physicians in its territory enrolled as members; does the medical work for its city and its county; has a meeting on the first Friday evening of each month, with a dinner before the scientific program; pays its secretary; pays the county and State dues for its members; pays the dues for its members as members of the League for the Conservation of Public Health, a State-wide organization; provides a \$5,000 indemnity policy for each member; pays for narcotic licenses for members; pays for the State renewal license for members; pays for the dinners served at its regular meetings; has all members present at every

meeting except when emergencies prevent attendance. The money paid by the city of Idaho Falls and the county medical service is paid to the society.—*Exchange*.

The names of more than 190,000 physicians were on the membership roster of the American Medical Association on March 1, 1924. These, of course, are the names of the members of our county medical societies. What a splendid army of influential citizens! What a splendid influence that army might yield through our more than 2,000 county societies if every man would do his full duty to his own society! Are you going to attend your society's meeting this year? Are you going to work—earnestly and persistently—for its success? Are you?

DO THE QUACKS REALLY DO NO HARM?

From Critic and Guide, Mar., 1924.

The retort is sometimes made, "If they don't do any good, at least they don't do any harm."

The "they" refers to the quacks of various brands, to the drugless and anti-surgery healers.

But this isn't so. If it were so, they would certainly meet with little opposition from our side. The fact is that by discouraging people from taking rational treatment, they induce them to neglect their cases until they become greatly aggravated, and sometimes until it is too late to do anything. Here is a case, one of many.

A man has had a stricture, a large caliber stricture. The stream was getting smaller, he had occasional difficulty with the urine, but felt quite comfortable. If he had taken treatment at that time the condition could have been cured rapidly. But through reading the quack magazines, he became opposed to scientific medicine, and wrote to one of the quacks advertising in one of those magazines. That quack told him not to use any medicine of any kind, not to subject himself to any treatment, but just live a "natural" life; be out in the open as much as possible, have cheerful thoughts, keep his bowels open, and so forth.

So far so good. But the stricture refused to be influenced by the open air, and kept getting smaller and smaller, and the stream became narrower and narrower, and now and then there would be complete retention for a few hours. And yet the man was so biased that he did not apply to a physician, only living a "natural" life in the mean-

while. And to make a long story short, the stricture closed up entirely, the man had acute retention for twenty-four hours, had to be rushed to a hospital, where a suprapubic cystotomy was performed and the man's life thus saved. So narrow was the stricture that not even a filiform bougie could be passed.

O, yes, the quacks do harm. Outside the direct positive harm that some do by their ignorance, they do a great deal of negative harm by preventing the patient from taking the proper treatment at the proper time.

INFORMING THE PUBLIC.

In the sphere of teaching, the medical profession has not achieved a commanding position. The public has not been fully apprised of the information which is rightly theirs and which would contribute to their well being. An attitude of aloftness prompting a rather negative activity in the affairs of men at large seems too prominent in the ranks of medical men—a tacit acceptance in general that any form of publicity emanating from or referring to a physician, even in the interests of society, is a breach of the professional code in that attention is called to that particular physician. Such attention is called a form of personal advertising which is abhorrent to all true disciples of medicine. This deadening point of view greatly militates against professional men being the leaders in society's uplift that their scientific knowledge, which knowledge it should be their duty to promulgate affords them the opportunity of being.

Now is the time to inaugurate an intensive program of acquainting the people with the functions of scientific medicine in the body politic. Here and there individual physicians have brushed aside the traditional barriers and have told the story of medicine in plain language. There is no reason why the romance of the healing art, its slow mastery through centuries over disease should not be told. Let us all swing farther away from the narrow confines of our calling, make larger contacts with men and things in the other circles of life, and energize ourselves into a sales force in biologic education. Society needs the knowledge we possess; it has given but trifling thought in its structure of education to the real foundations—the biologic studies.

Medicine is no more to be hedged about with myster and heavy diginity than any other calling. We have great pride in our achievements, and there should be no dis-

credit to us is heralding them to the world. At the same time, we must learn to tell the truth about our limitations, about the diseases which baffle and the paucity of knowledge concerning them. No presentation of truth can mar the part of true medicine in the destiny of man.

Surely public activity of this character could not be constructed as advertising, which the code of ethics defines as direct or indirect laudatory articles in the public press concerning a physician's management of cases.

If group medicine were responsible for like advertising it would justly be subject to condemnation. But if the members of a group, believing that co-operative practice is beneficial to the public welfare, acquaint the people with their purposes, to me it seems in consonance with the views outlined above.

So the necessity for careful selection of the personnel of the group is evident. The members must have the same aims, be enthusiastic for success, willing to make sacrifices that the objectives may be obtained, positive heralds of the co-operative method and loyal to each other.

This is what the Legislative Bureau has attempted to do in relation to the physicians and through the physicians to reach the legislator and set before him the information which is rightly his and which would help him in making his decisions for the interest of the public good in public health matters.—R. B. in A. M. A. Bulletin.

MEDICAL SOCIETY OF NEW JERSEY.

The following changes have been made in the Official List since it went to press March 1st:

Omitted from Alphabetical List.

Adams, John K., 3 Prospect st., East Orange.
Bramble, Halsey E., Elmer.

Re-instated Members.

Butler, Samuel S., Kaighn av., Camden.
Clement, Lavina B., Kings Hwy., Haddonfield.
Crawford, Georgina, Central av., East Orange.
Fleming, Charles L., Pennsgrove.
Mount, Walter B., Plymouth st., Montclair.
Pierson, Henry C., 530 Locust st., Roselle.
Pierson, H. Morton, 107 Walnut st., Roselle.
Schaster, H. A., U. S. V. Bureau, Pittsburg, Pa.
Sherman, Alton L., Northfield av., W. Orange.
Smith, Malcolm K., Maplewood av., Morristown.
Tilton, W. R., Short Hills.

New Members.

Berg, S., 530 Central av., Newark.
Brooks, C. D., Hasbrouck Heights.
Hahn, P. S., 48 W. Blackwell st., Dover.
Krone, W. F., 39 Lincoln Park, Newark.
Linke, Julius P., 245 Front st., Plainfield.
Walsh, T. M., Hasbrouck Heights.

Hospital Standardization Committee Report.

John C. McCoy, M.D., Chairman.

Report of a meeting of the Hospital Standardization Committee of the New Jersey State Medical Society, Representatives of the Boards of Managers of the Standardized Hospitals of the State, and Representatives of The Nurses' Associations of New Jersey held at The Robert Treat Hotel, Newark, N. J., March 30, 1924.

Dr. J. C. McCoy, chairman of the Hospital Standardization Committee, explained the object of the meeting, which was to receive the report of the special committee of nine appointed to investigate the nursing situation.

Dr. H. B. Costill, chairman of the sub-committee, read the report as follows:

The committee of nine appointed by you at a conference of the Hospital Managers, the Nurses' Organization, and the Hospital Standardization Committee of the Medical Society of New Jersey held in Newark on March 11th, 1923, to consider the question of the shortage of nurses in our State, and to formulate plans whereby this shortage could be relieved, would submit the following report.

Your committee has held a number of meetings, and endeavored to view the question from all angles. First: As to the advisability of securing legislation. Second: Incorporating the subsidiary nurse in the class of other nurses in training in hospitals. Third: The training by the visiting nurse in the municipal hospitals; and have finally unanimously decided to submit to you the plan organized and successfully followed by Miss Carrie Gerhart, R.N., of East Orange, New Jersey and known as the Visiting Nurses' Organization.

The operation of the plan in brief is this. (a) That the object was to furnish home nursing at moderate cost; (b) that educational and age requirements were such as not to interfere with the higher standards demanded for hospital nurses working for an R.N.; (c) that the length of the course was one year; (d) that the training was received in the Nurses' Settlement, the home of the pupils, in the elements of housework and simple dietetics; (e) that classes and lectures were held regularly throughout the course; (f) that bedside instruction was given in the home by the graduate R.N. nurse acting as supervisor, accompanying the pupil and taking the professional responsibility of the case; (g) three months is spent in a hospital, where experience is gained in the general wards, and in the children's and maternity wards; (h) during their seventh month pupils ("gray nurses" as they are called) are sent to private cases deemed suitable by their superintendent, but they continue to work under close supervision by daily or frequent visits from graduate supervisors. The price paid for this service is \$19.00 per week; (i) at the end of a year the pupils receive a certificate issued by the Visiting Nurses' Association.

The requisites for such a course are: 1. A well organized Visiting Nurses' Association employing a sufficient number of registered nurses to act as responsible supervisors; 2. a superintendent of unusual executive ability and a personality which inspires enthusiasm in her pupils and makes them eager to meet the daily emergencies of their

vocation with sympathy, often entailing self sacrifice; 3. a hospital ready to welcome these pupils and to give them the opportunity of experience and observation in institutional methods; 4. a class of healthy, intelligent women eager to learn how to meet the home emergencies in the homes of the sick, as well as the technique demanded in the care of the sick, especially in the home of moderate means, for which this service was designed.

This plan has now been working successfully in Orange for four years. The demands for these nurses coming both from the medical profession and from individuals is far greater than can be supplied. The corps of supervised nurses number now fourteen, five times that number could be kept constantly busy. It would seem that while this organization is entirely distinct from hospital, or the hospital training school, yet for successful operation it is necessary that the hospitals lend their active and hearty support. When we consider the need of a greater number of nurses that is so keenly felt, not only by the people, but by the hospitals also, your committee can hardly conceive any hospital withholding its active co-operation and support.

Your committee would advise that in each hospital center in the State that there be established a branch of the visiting nurses' association. That this be done by the co-operation of the hospitals, (that is representatives of the boards) by representatives of the nurses organization, and of the physicians.

It would seem to your committee that in the logical workout of this scheme an association of hospital managers would be advisable.

Harry B. Costill, M.D., chairman.

Members present at the meeting this report was adopted: H. B. Moorehead, Mrs. F. W. Tooker, Mr. W. W. Farr, Miss Florence Dakin, Miss Carrie E. Gerhart, Charles C. Stout, John C. McCoy, Henry B. Costill.

The discussion was opened by Miss Carrie E. Gerhart, with the following outline of the work done in the Oranges:

"We in the Oranges have been blessed by having a well established Visiting Nurses Association, first as a part of the regular hospital nurses' training, dating back forty years ago, until about twenty years ago it was done from the hospital. Since then it has been president, now our honorary president, a woman of broad vision, Miss Margaret H. Pierson, and this course was part of her plan to help relieve this need in the Oranges. I have been most fortunate to be put in charge of the work to help her carry out her idea. She gave our association the wonderful Nurse Settlement House, where pupils could be housed while they were receiving their training, and then we found we must put it on a broader basis so that we could take pupils who could not come to the settlement to live. In order to have the hospitals feel that we were not infringing on their work or interfering with their source of supply, we made it a rule to take absolutely no one who was eligible for the regular hospital training, and another step was to require the payment of a fee of \$50.00 for this course. The applicants were to have an education equal to the completion of grammar school, but as to that we afterward had to be pretty broad, because we found many applicants did not have the re-

quired grammar school education, but we found among these applicants many who had a great natural aptitude and a real desire to do the work. Some of these were perhaps the high class servant type, and we found an applicant belonging to this type with good training in a nice home the finest possible material for our need. The age limit extended from 18 to 45 years. We also procured scholarships so that a pupil who could not pay the entire fee at the time of entering training was able to take the course and pay back the fee when she began earning money. The training school provided nothing beyond the housing, maintenance and instruction of the pupil, except the winter coat when the pupil assisted in the visiting nursing field work. Otherwise the uniform was furnished by the pupil herself, as well as the books. The first two months are a probation period, one month of that time is spent at the settlement with the housework under the house mother; during which time she instructs the pupil in the preparation of food, planning of meals, buying of food, and the management of the house in general. This, I find is a splendid thing. Some, of course, have a fair idea of this type of work, but even at that, one month is better than none in order to establish routine. When we took in two pupils it was easy to give them each a month at the Settlement, but one month we had four pupils, and they would be in training four months at that rate before they would have this month of training. After instruction she is allowed to go out with the visiting nurse in the field. The visiting nurses are graduate nurses, and they of course have their districts. We have between 30 and 35 deliveries a month, and one of these pupils after two months in the school told me one day that she seen 11 deliveries in the homes and one Caesarian operation in the hospitals. So, during their first four months they assist the doctors and graduate nurses at deliveries, and in the after care of the mothers and babies, and the care of the chronically ill and aged patients. As soon as we find that they are capable of handling the chronic patient alone, we let them take care of them on a visiting basis. After four months they are sent into the hospital for three months, where they are put into the women's medical and surgical wards, the children's and maternity wards, and the diet kitchen. We keep on their classes and lectures all through the year. We do not depend on the hospitals to give them classes or lectures. The Orange Memorial Hospital has kindly permitted them to attend to some of their classes for their pupils, but we find that they are somewhat too deep for them, for afterward they will come to me and say, "Miss Gerhart, what did mean." We make all their classes and lectures as practical as possible. Our school pays them and the hospital has nothing whatever to do with them except to maintain them while they are having their hospital training period, and we in turn make sure that they are not a responsibility or care to them. They are able; when they get to this part of their training, to take T. P. R., and give general bedside care. This usually brings them to their seventh month in training, and they leave the hospital. We then put them

out on cases for full time in the homes, under strict supervision, and there is a great demand for them now. Their services are booked ahead months in advance. They take care of confinement cases right from the beginning, mothers leaving with new babies right from the hospital, who need care and help with adjusting themselves to new conditions, and cases where a patient requires care and there is some housework to be done. In cases where the housework is being done we have to supervise very strictly, or, in some cases the pupils would be worked to death. Where housework is combined with nursing, if there is any amount of nursing to be done, it becomes a most heavy task. There is no laundry work done by these nurses, with the exception of infants garments. As I have said, these gray dress nurses as they are called, are in great demand. While they are pupils a charge of \$18.00 a week is made for their services, \$1.00 for supervision, and if the family cannot do their laundry with that of the house a charge of \$1.00 is made, making it \$20.00 a week in all. After they have gone all through this period and finish the year, we give them a final examination, and, if satisfactory, we certificate them. We then put them out on cases for another year under supervision. We charge \$1.00 for supervision and \$25.00 for the nurse, \$26.00 in all, and the nurse now receives \$25.00 of this, the laundry becoming the nurse's responsibility. Now we find that after this second year is finished we are faced with the difficulty of holding these nurses in check from charging \$30.00 a week, after two years, for confinement cases and contagion. On the other hand we have a large number of women, who have no training whatever, who cannot even take a temperature, who are charging these rates and more, with no standard as to what they shall do or charge. What can be done in the community to regulate these charges? In our case we find with few exceptions the graduates of these courses so valuable to their training, and are so anxious to be attached to something tangible that they are glad to keep to the arrangement, and they even want to organize among themselves, to agree to do "that" or not to do "this" or whatever their school would suggest as a code. We find that they are grateful for their training, and seem to want to feel that they are backed up by something beyond themselves to do whatever they are qualified to do. Could they put this training on that basis if it were done entirely in the hospitals?

"It is perfectly evident that the course must include some hospital training, but it seems to me that it would not do to put this course entirely into the hospitals. It would not equip them as "home nurses" and neither would it be fair to the nurse taking the regular hospital training. Would she be the good home nurse you want her to be, unless she got some home training? The avenue need not necessarily be the Visiting Nurses' Association, it could be done through some municipal child hygiene or Day Nursery or something of that kind. Let them start them, home training in this institution under the charge of a graduate nurse, who is thoroughly in sympathy with the course. When they are ready to be sent to the hospital, the hospital serving the com-

munity might be selected, and, with as much home training as possible, it would be found that this method also would be practical. In order to finance the course, the pupils pay \$50.00, and she brings \$18.00 a week for the last five months of the first year, after that a dollar a week of the second year she works, and while we have only approximated the course, we find that we have made no money on the course, but it has not cost us anything to make this course, a feature of our activities. The up-keep of the home, the salary of the supervisor, and administration is not charged against the cost of training, although without it, it would be impossible for a proper training to be given. The more pupils there are in training, of course, the less expensive the cost of training, of necessity, would be."

After a general discussion on motion by Dr. Banker, seconded by Mr. W. W. Farr, the report of the committee was accepted, and the recommendations in it for the organization of Visiting Nurses' Associations, adopted. It was further directed that the various organizations affiliated with the committee, viz.: hospitals, nursing organizations and physicians be urged to establish such nursing centres, and that these organizations be furnished with copies of the report of the sub-committee and with plans for the establishment of such centres, and that accounts of the meeting and the committee recommendation be given to the public press. On motion the meeting adjourned.

Not only is the plan inaugurated by Miss Pierson, and directed by Miss Gerhart, successfully meeting the conditions for a better trained practical nurse for those of moderate incomes, but a similar course, perhaps on a larger scale, is also operating in Boston, under the name of "The Household Nurses' Association," 222 Newberry Street, Boston, Mass. If any community in our State contemplates the establishment of such a course for trained attendants, Miss Gerhart will be glad to meet with those sponsoring such a movement, or will demonstrate the details of the Nursing centre in the Oranges. It is to be hoped that with the establishment of several such centres in the State, better trained, more capable and supervised practical nurses will replace many now posing as practical nurses in the communities, and will assist in relieving the shortage of nurses. Such a plan should in no manner interfere with the educated and well equipped R.N. nurse; on the contrary this opens a new field for her endeavors, where in place of devoting her time to an individual patient, she would exert her influence, through the aides under her supervision upon a larger number of the sick in the community.

NONSENSICAL CHIROPRACTIC TWADDLE.

In Newark Evening News, Mar. 17th.

Law Sought by Medical Men Called Admission of Chiropractic's Value.

To the Editor of the News:

Sir—It seem strange that each year the Medical Society is having its representatives in Trenton trying to have laws enacted so as to make their profession a monopoly to enable it to dictate to a supposedly free born public just what and how they must live.

Bill 159, which the society is trying to force

upon the people of New Jersey, admits that the value of chiropractic is acknowledged.

I, for one, after years of treatment by medical doctors and finally advised that an operation was absolutely necessary, am glad to say that, after taking several adjustments from a chiropractor, I am enjoying as good health as any one desires.

If chiropractic did not have its value in restoring health, I am quite sure it would die of its own accord, but as more and more people are being converted and results are being shown, I can readily understand why the medicos are fighting to retain their "graft" by the doping and fooling of the public. If, as they claim, they want to protect the public, why do they write all prescriptions in Latin, when the poor public is required to pay ninety cents or a dollar for a five-cent article?

This bill should not be allowed to pass, for it is up to the public to decide what it wants.

D. D. H.

Physicians Need Imperturbability.

In the physician or surgeon no quality takes rank with imperturbability, and I propose for a few minutes to direct your attention to this essential bodily virtue. Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in movements of grave peril, immobility, impassiveness, or, to use an old and expressive word, phlegm. It is the quality which is most appreciated by the laity, though often misunderstood by them; and the physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients. In full development, as we see it in some of our older colleagues, it has the nature of a divine gift, a blessing to the possessor, a comfort to all who come in contact with him. You should know it well, for there have been before you for years several striking illustrations, whose example has, I trust, made a deep impression.

As imperturbability is largely a bodily endowment, I regret to say that there are those amongst you, who, owing to congenital defects may never be able to acquire it. Education, however, will do much; and with practice and experience the majority of you may expect to attain to a fair measure. The first essential is to have your nerves well in hand. Even under the most serious circumstances, the physician or surgeon who allows "his outward action to demonstrate the native act and figure of his heart in complement extern," who shows in his face the slightest alteration, expressive of anxiety or fear, has not his medullary centers under the highest control, and is liable to disaster at any moment. I have spoken of this to you on many occasions, and have urged you to educate your nerve centers so that not the slightest dilator or contractor influence shall pass to the vessels of your face under any professional trial. Far be it from me to urge you, ere Time has carved with his hours those fair brows, to quench on all occasions the blushes of ingenuous shame, but in dealing with your patients emergencies demanding these should certainly not arise, and at other times an in-

scrutable face may prove a fortune. In a true and perfect form, impertubability is indissolubly associated with wide experience and an intimate knowledge of the varied aspects of disease. With such advantages he is so equipped that no eventuality can disturb the mental equilibrium of the physician; the possibilities are always manifest, and the course of action clear. From its very nature this precious quality is liable to be misinterpreted, and the general accusation of hardness, so often brought against the profession, has here its foundation. Now a certain measure of insensibility is not only an advantage, but a positive necessity in the exercise of a calm judgment, and in carrying out delicate operations. Keen sensibility is doubtless a virtue of high order, when it does not interfere with steadiness of hand or coolness of nerve; but for the practitioner in his working-day world, a callousness which thinks only of the good to be effected, and goes ahead regardless of smaller considerations, is the preferable quality.—From *Aequanimitas*, William Osler.

Standard Test for All Who Treat Safest Means of Protecting Public.

To the Editor of the News:

Sir.—Your admirable editorial on the abuse of the title "doctor" deserved a better reception than villification by an ignoramus and abuse from a pro-German. To persons of correct, even if elementary information, it is not necessary to point out the basic ignorance of facts that was demonstrated by one letter, but the difficulty is that relatively few persons have a practical and working knowledge of the elementary facts and principles of physiology and hygiene and others are easily led to admit false claims, plausibly presented, and to be thus misled into serious situations.

That there is a great field of usefulness for any one who will try to lead people to preserve their health and avoid disease, whether he calls himself a naturopath or by any other title, is undeniable, but how absurd to claim that ignorance is a desirable qualification for such work. Your editorial merely claimed that it should be required that men permitted to engage in such work should first demonstrate their competence to do it correctly. What reasonable objection can there be to such a requirement? All doctors worthy of their title should be and are naturopaths in reality.

Who ever knew a physician of recognized standing who did not make it his chief business to direct his patients in methods of healthful living? The trouble is that the people go right on defying natural laws and then expect the doctor to cure them as the mechanic repairs a broken machine. The human body is merely a complicated chemical laboratory. The chemical processes that go on in it are far more abstruse and complex than those conducted in the laboratory of any chemist. While the simpler rules of health are easily followed, it is inevitable that frequent occasions will arise in which the bodily system suffers accidental violence.

It is true that many of these conditions are beyond the power of the most learned physician to correct, but how foolish to claim that where the best qualified must fail the unquali-

fied can succeed. It is not in the interest of the doctor that we would require suitable preparation and training of men who are to take the lives of others into their keeping, but in that of the unfortunate masses whose lives prevent them from becoming informed and who, therefore, are and must be incompetent to judge.

For the protection of these people the State provides judges who are, or should be, competent to determine the fitness of practitioners to deal safely with the public. Any man, whether an M. D. or a naturopath, who desires to dodge this test must be a charlatan and an imposter, in the very nature of the case. By all means let us have the very best men in charge of human lives, lest, by the leading of the blind by the blind, they both fall into the ditch, which for the one is the grave and for the other the penitentiary.

H. H. Rusby.

Newark Evening News, Mar. 7th.

Years of Medical Training Argued Against Short Drugless Courses.

From Mar. 7th Newark Evening News.

To the Editor of the News:

Sir—I have been deeply interested in letters and editorials in the News on medical and drugless healing and have been appalled at the ignorance displayed by some of your correspondents. Can it be possible that in this day and generation people of brains can be so duped and deceived? It would be amazing if it were not so pathetic.

Your Wednesday night's editorial was commendable as it touched upon the educational requirements the State holds for medical men and drugless healers, and even the most unthinking and unreasonable person must admit the unfairness of these laws. How can it be just? Before a man or woman can take the State examination to receive his license to practice medicine in the State of New Jersey he must first be a graduate of a class A medical college and have spent one year as a resident intern in an approved hospital. Before he can enter this class A medical college, he must be a graduate of an academic college, holding a B. S. or B. A. degree. Before he can enter an academic college he must have a four-year high school course. Thus a man must spend twelve or thirteen years of hard, thorough study preparing for his right to practice medicine.

Then behold—any butcher, truck driver, street cleaner or any one else who can raise \$300 and take a six-months course in a so-called "college" of drugless healing, takes his State examination, hangs out his shingle next to the M. D., is hailed as "doctor," and is, to the minds of the laity, as equally informed on the subjects of anatomy, physiology, etc., and as equally able to treat the human ills.

How many people know why there is no medical college in New Jersey? Because there is a law prohibiting the dissection of any human body, and no student can be adequately trained in medicine without actually working on and studying the body.

How many men would intrust any mechanic who had studied the mechanism of an automobile by pictures and charts only, but had never had the motor to pieces and seen and

felt how each part worked, to repair his automobile? Yet weekly hundreds of people are intrusting the intricate machines of their bodies to men untrained and uneducated in the most fundamental lines of the physical make-up.

To those who insist the doctors do not want these cults to exist because it deducts from their practice, hasn't the welfare of human life always been the watchword of physicians? Has any worthwhile thing been discovered to forward the advance of medical science that doctors have not availed themselves of the opportunity to help their patients? Look at the newly discovered cure for diabetes, and the use of radium for the cure of cancer.

Was the attitude of the doctors to hide these discoveries that they might keep these people as chronic patients? The idea is absurd. Medicine is the oldest of all sciences. If all illnesses were attributed to mere "bumps on the spinal column," to quote from the catalogue of a local "drugless healing" school, would it not have been discovered long since by the men of brains and ability who have spent their lives studying the subject?

I can not understand the feeling of antagonism toward medical doctors which is so prevalent. Surely they, as a class, do more for their race than any other class. "To err is human," therefore they are bound to make mistakes, but how much do we owe to their study, knowledge, patience and ability? And I think it is an interesting bit of psychology that the doctors are not rushing around trying to defend their science. Well they know that they are right. What would the world be if all doctors dropped their medicine and depended on naturopathy?

It is not the object of this letter to discuss the number of cures by any school, but if your correspondents of Saturday and Monday nights will consult any reliable physician they will undeniably hear some pretty pathetic stories of the mistakes and errors made by the drugless healers which have been brought to him to correct.

It is up to those in authority in the State to protect the ignorant, and if these cults are to exist, then let it be seen that they must have the same scientific training that is required of the medical doctor.—FAIR PLAY.

Lay Education Committee Begins Concrete Work.

From the Illinois Med. Jour.

The Lay Education Committee of the Illinois State Medical Society announces the organization of a service bureau at the rooms of the Chicago Medical Society, 25 East Washington Street, under the present direction of Miss B. C. Keller, professional sales and publicity counselor.

This bureau is designed to furnish accurate, first-hand information about the achievements and activities of the medical profession in Illinois through every available medium to the public interest. The lay press in Illinois, press syndicates, and national publications having a considerable circulation within the state will be supplied with news and feature stories emphasizing the doctor's point of view on every current topic that touches his interest. The work of the Speaker's Bureau will be pushed

and opportunities provided for effective talks from radio broadcasting stations and before representative and influential men's and women's organizations. In sections where newspapers are unfriendly or ineffectual, direct mail methods will be used by branch societies as a unit.

It is proposed that material for this educational campaign be obtained by working closely with the officials and the chairmen of standing committees of state, city, branch and county organizations. Miss Keller's job is to help busy doctors identify events of news value in their own organizations and to take off their hands the mechanical labor of putting such news in shape to command lay interest and attention. She can do effective work only if she knows what you want, for a mass of news matter not in line with educational needs as you find them in your own practice and your own community will defeat the ends for which this campaign is designed. The committee urges that you get in touch with this service bureau and keep in touch with it. Give yourself a chance to get full value from the educational fund by helping to direct its plans and policies.

THE COMMITTEE ON LAY EDUCATION.

Jas. H. Hutton, Chairman; Wm. D. Chapman, Chas. J. Whalen, R. R. Ferguson.

Lay Champions of Medical Progress.

In 1923 a national lay organization was incorporated for the following purpose:

First, to encourage and aid all research and human experimentation for the advancement of medical science.

Second, to inform the public of the truth concerning the value of scientific medicine to humanity and to animals.

Third, to resist the efforts of the various persons and societies constantly urging legislation dangerous to the health and well being of the American people.

In asking for the support of the public in an effort to check the growing menace to the health of the people, the president, Thomas Barbour, of the Agassiz Museum of Comparative Zoology, has sent out a letter which reads as follows:

"We are writing to ask your co-operation in an effort to check a growing menace to the health of the people.

"Within the last fifty years many societies have been organized to prevent the advancement of medical science by experimental methods, to break down the bulwarks of preventive medicine, and to substitute for the scientific treatment of disease various forms of pseudo-science and quackery. We are in a position to know that these organizations have reached the danger point. It must be fully understood that if this anti-medical program should succeed, the hands of the doctors would be tied and no further progress in experimental medicine could be expected. No reliable insulin would be available for diabetics, no antitoxin would be possible for diphtheria or lockjaw, no vaccine could be procured to protect the country against smallpox, and it would be utterly impossible to test such essential drugs as ergot, pituitrin and digitalis.

"With a view, therefore, to resisting the efforts of these societies there has been organized and incorporated a National lay society

"Friends of Medical Progress." This organization will undertake to inform the public of the truth concerning the value of scientific medicine to humanity and to animals, and will oppose legislation dangerous to public health. By so doing it will perform a highly important function, hitherto assumed with difficulty, as a civic duty, by the medical profession.

"The society hopes to extend its influence throughout the United States. How far it will be able to do this depends upon the response of the public. We ask you to co-operate with us."—*Illinois Med. Jour.*

Governor Silzer Approves Periodic Medical Inspection.—Governor Silzer has signified his approval of the campaign being launched for a periodic medical examination of every man, woman and child in New Jersey, and offered every possible assistance.

"I have learned with interest," the Governor says in a letter to the New Jersey Committee on Periodic Health Examinations, "of the campaign which you have begun in the fight against disease and ill health. I am much interested in your plan of encouraging periodic examinations, at least once in each year, so that the individual may be apprised of his or her condition of health. I do it myself and I advise others to do it.

"After all, no one can expect to be happy unless he is healthy and no one can expect to be healthy unless he takes care of his body."

The New Jersey Tuberculosis League and its thirty-six local associations co-operating with state and local boards of health and medical societies in the campaign will try to reach every man, woman and child in the state, so that the life span may be increased.

Periodic Medical Examinations.

Physicians must recognize a rising movement among the laity demanding that physicians prepare themselves to make intelligent reports on the physical state of adults who are apparently healthy. The scientific basis on which this demand is founded is the fact that diagnostic methods are refined to a sufficient degree to detect abnormalities in their incipency, while they may be corrected.

The civic basis on which is based the expectation of response by the public is twofold: 1. the experience in the army in the detection and correction of defects; 2. The experience of tuberculosis workers in detecting and correcting defects caused by incipient tuberculosis; since incipient tuberculosis simulates most other diseases, the examiners have had the opportunity to prove the value of the examinations in other conditions besides tuberculosis.

Two of the best demonstrations of the value of periodic physical examinations have been: 1. The regular examination of school children. 2. The demonstration of the health supervision of policyholders by the Metropolitan Life Insurance Company.

Two groups of persons are vitally interested in periodic medical examinations: 1. The people generally, who are the subjects for examinations. 2. Physicians generally, who will make the examinations.

Civic organizations that are interested in health subjects are rousing the people to go to

their physicians to be examined and to have their defects corrected; and Departments of Health are spreading the propaganda in order to reduce the increasing death rates from diseases of adult life. There are now literally thousands of persons ready to pay their good money for scientific examinations.

It is now the privilege of physicians to gather the fruits of the sentiment for examinations which has been rapidly rising ever since the World War. Here and there physicians are preparing themselves to make examinations. The most conspicuous example is that of the Kings County Medical Society that devoted its 5 o'clock lecture on March 21st to a demonstration of the methods by Dr. Haven Emerson, and offers to examine one hundred physicians in order to teach them the methods of the examination. The time has come when the organized medical profession of New York State should take up the subject of periodic examinations as one of its major activities.—*N. Y. Med. Jour.*

Hospitals; Sanatorium.

Alexian Hospital, Elizabeth.—Efforts will be made very soon to raise \$20,000 for the Alexian Brothers Hospital, to be known as the improvement and deficit fund. The money will be used to purchase electrical necessities for the work at the hospital.

Beth Israel Hospital, Newark.—The effort to raise a \$1,500,000 building fund is under way and Mrs. Parsonnet, widow of Dr. Victor Parsonnet, a former president of the medical staff, has been added to the list of vice chairmen having charge of the campaign. The official endorsement of the Newark Conference of Jewish Charities was given recently to the campaign to be undertaken by Jewish citizens of Newark to raise \$1,500,000, with which to replace the present Beth Israel Hospital with a modern hospital plant.

Bridgeton Hospital.—The campaign to raise \$200,000 for this hospital was put "over the top." The goal set was reached and there was a goodly margin above that amount. Large subscriptions for establishing several memorial rooms are included in the amounts. A large new building will now be added to the present hospital, supplied with the most modern facilities and equipment.

Perth Amboy Hospital Training School.—The Commencement Exercises of this school were held on April 10th, when seven nurses graduated. Diplomas were given by Dr. George W. Fithian, and gifts from the physicians and surgeons of the staff were presented.

Soho Isolation Hospital.—The monthly list of patients for March was scarlet fever, fifty-seven; diphtheria, thirty-one; measles, twenty-two; German measles, 1; ophthalmia, 2; tuberculosis, 9; other diseases, 8. Deaths during the month totaled thirteen. Of these, five were tuberculosis patients; one scarlet fever with a complication of acute nephritis and

streptococcic septicaemia. Four of the seven, deaths from diphtheria were moribund cases, living only a few hours after admission.

Trudeau Sanatorium.—During the forty years of its existence this famous sanatorium has established one of the first training schools for nurses, a widely known School of Tuberculosis, the first to be established in the world, and a fellowship system whereby young physicians overtaken by tuberculosis may engage in laboratory or other research work and earn their living while regaining their health.

Gifts to New Brunswick Hospital.—The New Brunswick. The donations will come out of contribute \$10,000 to the St. Peter's General Hospital, and a like amount to the Middlesex General Hospital for the construction and equipment of a special operating room for crippled children and general orthopedics in each institution. In addition to the contributions of \$10,000 to each of the hospitals, the Elks have contributed \$1,000 to the general building fund of each hospital. The action by the Elks is the greatest civic effort made by a fraternal organization in the history of New Brunswick. The donations will come out of the general treasury of the Elks, and there will be no drives among the members or any public affairs to raise funds, the members voting to pay the donations from the dues and initiation fees paid by members.

Death.

ROHN.—At the Newark Memorial Hospital on February 21, 1924, Dr. John Philip Rohn of Newark, aged 39 years.

Dr. Rohn graduated from Cornell University Medical College, New York, in 1908. His death followed an operation for appendicitis.

We have not yet received copy of the action taken by the Burlington County Society on the deaths of Drs. Hollingshead and Prickett.

—Editor.

Public Health Items.

Forty-five crippled children of school age in Grand Rapids, Mich., who have never attended school before, are now enrolled in an orthopedic department which has been organized recently in one of the elementary schools.

As part of the training for health given in the schools of Latvia, a new law requires instruction on the dangers of alcohol. The minister of public instruction must revise the school program to include this instruction within a year.

Ten years ago, in 1913, Buffalo physicians attended at the birth of 6,642 babies or 55.9 per cent. of the whole, and the midwives attended at the birth of 5,225, or 44.1 per cent. of the total of 11,867 births for the whole city in that year. The past year, 1923, Buffalo physicians attended 10,018 or 81.06 per cent. of the births, while the midwives attended 2,340 or 18.94 per cent. of the total of 12,358 births in the city.—Buffalo San. Bull.

Newark Health Report.—The February report shows 478 deaths during that month, or a death rate of 12.9 per 1,000 of population. The principal causes of death were: Tuberculosis, 33 cases; cancer, 43; apoplexy, 29; organic heart disease, 83; pneumonia, 51; Bright's disease, 34. There were 941 births recorded in February.

New Jersey Mortality Report.—During the month of December, 1923, there were 3,304 deaths reported to the State Department of Health. The death rate for the month was 11.43. There were 406 deaths among children under one year of age, 168 deaths of children over one year and under five years of age, and 1,319 deaths of persons aged 60 years and over. The principle causes of death were: Typhoid fever, 15; diphtheria, 39; tuberculosis, 223; cancer, 263; pneumonia, 190; Bright's disease, 284; diseases of nervous system, 374; diseases of circulatory system, 665.

During the month of January, 1924, there were 3,481 deaths reported, or a death rate of 12.01. The principle causes of death having been: Thyroid, 5 cases; diphtheria, 32; influenza, 31; tuberculosis, 226; cancer, 253; diseases of nervous system, 405; pneumonia, 278; Bright's disease, 350. There were smallpox cases reported in following counties: Camden, 56; Union, 27; Essex, 8; Sussex, 6; Gloucester, 3; Monmouth, 1. There were treated in the clinics 1,461 cases of syphilis; 512 gonorrhea and 8 of chancroid.

The State Department has made special inquiry in the 119 cases of smallpox reported from January 1 to February 20, with the following results:

No. of patients never successfully vaccinated	111
No. vaccinated within 7 years prior to attack	0
No. vaccinated more than 7 years prior to attack	7
No. cases data not obtained	1

From the table it will be noted that 91 per cent. of the 119 cases of smallpox reported occurred in persons who had never been successfully vaccinated, and that no cases occurred in persons who had been successfully vaccinated within seven years. Seven cases occurred in persons who had been vaccinated more than seven years prior to their attack. All these cases were adults who had been vaccinated in childhood. There were several instances in the outbreak in which all the members of a household were exposed to infection at the same time and all were later taken ill with smallpox except those who had been successfully vaccinated or had previously had smallpox.

Decrease in Contagious Diseases.—A decrease of 2,765 cases of contagious diseases during the year 1923 from the number in 1922 is reported by Health Officer Craster in the March issue of the bulletin issued by the Department of Health. The greatest decrease was mainly under the heads of influenza, with 1,462 fewer cases, and whooping-cough, with 1,124 fewer. There was a notable decrease in all other forms of contagion, however.

Scarlet fever shows a decrease of 907 cases. The number of cases in 1922 was 1,503, while those in 1923 totaled only 596. Tuberculosis

showed a decrease of sixty-three cases and typhoid fifty-one.

Venereal Disease Division Activities.—Reports from forty-four venereal disease clinics in this State outside of New York City show that at the end of January there were 2,776 patients on the active list of the service.

Prevention of Goiter in Pregnant Mother.—The administration of 30 c.c. of syrup of hydriodic acid, or of an equivalent amount of iodine in any other available form, for a period of one month during the first half of pregnancy will protect the mother and fetus. Desiccated thyroid is too dangerous.—T. Clark: Pub. Health Rep.

Expert Assistance for Health Work.—The several divisions or bureaus of the state board of health should be equipped to provide the local health departments with the expert assistance that is needed to enable them to establish and maintain the various special lines of work as it becomes necessary and desirable to take them up.—W. S. Draper: Public Health Report.

Quack Advertising Barred.—At a meeting of the New York City board of health, recently, a committee of public spirited citizens was organized to enforce the law against quack advertisements appearing in foreign language newspapers.

Kissing Dangerous.—Dr. Donald B. Armstrong told the delegates at the Red Cross Regional Convention in session at the Waldorf recently that kissing was an "extra hazardous occupation" from the standpoint of health.

Crippled Children's School.—After nearly five years of preparation, the special school for crippled children in Newark is at the construction stage. At an outlay of approximately \$200,000, the city will get what Dr. Corson, the superintendent of schools, describes as the most complete and up-to-date school for crippled children in this country. It transcends the best features of the Cleveland and Chicago schools of like character, which, until now, have represented the last word in accommodations for the housing of physically afflicted pupils. With respect both to the observance of practical economies in the physical maintenance of the new school, as well as in the provision for the personal comfort, scientific treatment under proper auspices and conditions, and the educational interests of the afflicted children, the institution will, if its present promise is fulfilled, become one of the very best features of the city's school system.

Danger Signals on the Road to Health.

Every wise mother recognizes some of the physical danger signals that precede childish ills.

Unnatural fretfulness, sore throat, suffused eyes, or a snuffly nose; these are not disregarded nor is time lost in waiting to see if perchance the child may not "outgrow" them. Instead they are considered as useful symptoms which make it possible to prepare calmly and intelligently for what may later develop into measles or scarlet fever.

Very few mothers, however, recognize the mental danger signals that precede later nervousness or the development of peculiar and twisted personalities.

For this reason it is important for mothers to understand that if they are present in chronic or excessive degree, such childish personality traits as temper tantrums, extreme shyness, day-dreaming, jealousy, demands for attention, pugnacity, and similar conditions, should be thought of as presaging some kind of mental maladjustment in later life, and should be given immediate attention of a corrective nature.—Monthly Bulletin, Massachusetts Society for Mental Hygiene.

Public Health Society of Twenty Nations.

What is deemed to be a development of far-reaching importance for the improvement of public health conditions the world over, occurred recently in Geneva when medical representatives of twenty-one nations, including the United States, voted for an international society of public health officers.

The objects of the society will be first, to advance preventive medicine and public health administration from the international aspect; second, to exchange information on public health matters; third, to organize international conferences and the publication of reports and medical periodicals, and, fourth, to promote international activities through a health organization league.

The movement for the society was launched at the conclusion of a meeting of health experts who made a special investigation in England, similar to last year's investigation of hygienic conditions in the United States, the funds having been provided by the Rockefeller Foundation.

Any physician devoting himself to public health matters may join the society.

Personal Notes

Dr. G. E. De Schweinitz, Philadelphia, late president of the A. M. A. will be the guest of honor at the French Ophthalmologic Congress to be held in Paris this month. After delivering a lecture he will be presented with a playette and the Minister of Instructor will preside at the banquet in his honor.

Dr. Wells P. Eagleton, Newark, delivered an address on "Meningitis of the Basal Cisterna" before the Ear, Nose and Throat Sections of the College of Physicians and Surgeons of Philadelphia on February 20th, and on April 24th he read a paper on "Surgical Treatment of Cavernous Sinus Thrombosis" at the New York State Society meeting at Rochester.

Drs. Edward J. Ill and Edgar A. Ill, Newark, have temporarily removed their offices to 1078 Broad Street during the erection of their new building at 1002 Broad Street.

Dr. John M. Randolph, Rahway, underwent treatment in a Newark hospital recently.

Dr. Frank P. McKenstry, Washington, was recently elected an Elder of the Presbyterian Church there.

Continued on page XXII.

Journal of The Medical Society of New Jersey

Published on
the First Day of Every Month



Under the Direction
of the Committee on Publication

Vol. XXI, No. 6

ORANGE, N. J., JUNE, 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

THE PRESENT STATUS OF UPPER ABDOMINAL DISEASE.*

By **Damon B. Pfeiffer, M.D.,**
Philadelphia, Pa.

The great Billroth in his introductory lecture on surgical pathology and therapeutics emphasized the fact that the difference between internal medicine and surgery is in fact only apparent, for, he said, "The surgeon can only judge safely and correctly of the state of his patient when he is at the same time a physician. Moreover, the physician who proposes refusing to treat surgical patients, and to attend solely to the treatment of internal diseases, must have some surgical knowledge or he will make the grossest blunders." In the great increase of knowledge since Billroth's day it has become increasingly difficult for us to keep an adequate touch with other fields than those in which we move daily, but it still remains just as important that we keep pace with all real advances in diagnosis and therapeutics in order that we may give our clientele the best that the times have to offer. These Society meetings are evidence of the appreciation of this fact by its members and it is therefore my purpose to outline certain present day conceptions concerning the important organs of the upper abdomen.

I take it for granted that it is now generally recognized that the stomach is often only the mouth-piece for the entire gastrointestinal tract and for miscellaneous conditions as well. Approximately 50 per cent. of all gastric symptoms are due to extra-abdominal causes, infective metabolic or nervous. In 40 per cent. they arise from intra-abdominal disease, but not of the stomach, leaving only a bare 10 per cent.

which are indicative of an organic affection of the stomach itself and in many of these cases the stomach has become affected only secondarily. Those time worn diagnoses, gastritis, hyperacidity, gastric neurosis, etc., still serve a purpose in satisfying the patient while we deliberate and investigate concerning the underlying cause of his ills, but they no longer satisfy the alert physician who wants to know and desires to cure. Often enough the intrinsic diseases of the stomach in the early stages give less prominent gastric symptoms than extra-gastric disease, as for instance the type of cancer which develops insidiously and involves a considerable area of the gastric wall and regional lymphatics without localizing signs or symptoms or, the latent ulcer which may exist for months and years with relatively few periods of activity evoking characteristic symptoms. Contrast with these the cases of chronic appendicitis with little or no local evidence of the disease but a host of complaints of indigestion of various sorts. Or the legion of sufferers from gall bladder disease with or without stones who fail to give any characteristic signs or symptoms of hepatic or biliary involvement yet complain incessantly of weak stomach, heart burn, gaseous eructations, various forms of distress, or perhaps nausea and vomiting.

Symptomatic treatment therefore has but little place in the handling of abdominal disorders. Our knowledge of the behavior of these diseases and our diagnostic resources usually permit an accurate diagnosis upon which alone rational therapy must be founded.

A vast amount of literature has accumulated in recent years on the subject of ulcer of the stomach and duodenum. Its value is not proportionate to its bulk. The time has come to sublimate the muddy mixture and recover the essential truth.

There are only three important symptoms

*Read before the Salem County Medical Society, April, 1924.

of ulcer: pain, vomiting and bleeding. Of these by far the most important is pain. The pain has three chief characteristics; first, though it sounds like an Hibernianism, the intervals of freedom; second, its punctuality of appearance during the active periods; third, the relief by food or alkalis. There are only two ways of being certain that an ulcer is or is not present; first, by x-ray demonstration; second, by direct examination at operation. No history is so typical that a positive diagnosis may be made in the absence of one or other of these forms of examination. Per contra, the possibility of ulcer cannot be dismissed from the lack of any so-called characteristic symptoms or set of symptoms. More than one-fourth of all acutely perforating ulcers give absolutely no previous history of indigestion. This is an important and but little appreciated fact. Fortunately the great majority of chronic indurated ulcers do give from time to time symptoms which should definitely fix suspicion and demand verification or disproof by one or other of the only two methods at our disposal.

There you have the simple skeleton guide to success in diagnosis of this condition. Of course there is much other knowledge that is interesting and helpful, but these points hold pride of place and should never be pushed into the background by other features of lesser importance. With this thoroughly understood, we may make some other observations that will assist. The symptoms of duodenal ulcer are as a rule much more characteristic than those of gastric ulcer. In duodenal ulcer, as pointed out by Moynihan, the rhythm of symptoms is "food, comfort, pain—food, comfort, pain." In the case of gastric ulcer it is "food, comfort, pain, comfort." In gastric ulcer the pain usually comes on within two hours after eating, rises to a maximum and then dwindles. In duodenal ulcer the pain more often makes its appearance more than two hours after a meal and increases until food is again taken. Cold weather and acute general infections, such as colds or grippal infections, are apt to excite exacerbation of symptoms of ulcer. This is more characteristic of duodenal than of gastric ulcer. Complete remission of symptoms is as characteristic of chronic ulcer as any other feature. It is relatively easy in most cases to put an ulcer to sleep by medical treatment, care in diet and the lapse of a sufficient period of time. But it is impossible to keep this dormant ulcer asleep by any known practicable regimen. One after another system of

medical management has been devised and has flourished like the green bay tree on the delusion that a dormant ulcer was a cured ulcer. Time has shown the error and the problem of curing a chronic ulcer by other means than surgery remains unsolved. Cures must be subject to the test of x-ray or direct vision before they can be acknowledged as such. Only in this way can we be prevented from continuing to move in circles in the train of fresh futile suggestions. Moynihan, the most eminent living authority on ulcer, has furnished scientific observations on the time necessary for the healing of callous ulcer. In certain cases he has made only a jejunostomy on account of operative difficulties and the general condition of the patient. Feeding has then been conducted through the jejunum, leaving the stomach and duodenum entirely at rest, certainly amore favorable condition for healing than any system of medical management. The progress of the case has been followed by the radiologist. In no case did a chronic ulcer heal in less than 6 months and in some it required two and one-half years. Until our gastro-enterological friends give us evidence in the way of satisfactory follow-up work we must sadly conclude that their cures were either not ulcers or they were not chronic ulcers or they were instances of that remission of symptoms which is so easy to secure and so deceptive to interpret.

The punctuality of the pain is striking. During the active periods a man of regular habits, eating his ordinary food at regular times can set his watch by the appearance of the pain. This is an interesting phenomenon probably due to increased intra-gastric tension and spasm. Pylorospasm is almost invariably present at such times. This disturbs the acid regulatory mechanism of the stomach and duodenum. Normally, as gastric acidity mounts and reaches a certain point the pylorus relaxes and there is a reflex of alkaline duodenal contents. When the pylorus is in spasm this neutralization does not take place and the acidity mounts beyond that which is normal for that individual and the stomach is excited to force the barrier of the pyloric sphincter. This does not mean that all cases of ulcer show hyperacidity. Only about three-fourths of all cases of duodenal ulcer will give acid readings much above normal and only about one-fourth of the cases of gastric ulcer show this phenomenon.

Hyperacidity does not always mean ulcer nor does its absence rule it out. Acid is

not the only element of the gastric contents that is disturbed by pylorospasm and delay in gastric emptying, though it is the most obvious and ready sign in the majority of instances. It must, therefore, together with the whole paraphernalia of gastric analysis, be relegated to a subsidiary place in the diagnosis of ulcer. Relief by food or administration of alkaline substances is also striking and in many instances characteristic, but it occupies just the same place in forming our conclusions as the above and for the same reason.

The x-ray is worth all other diagnostic means put together in positive or negative diagnosis. When I speak of x-ray examination I am thinking more of the man who makes it than I am of the machine. It requires great experience to become accurate in the radiographic diagnosis of gastric and duodenal lesions, but that experience can be gained and is then reliable in this particular field to an almost incredible degree. In the best hands it falls but little short of 95 per cent. and is inferior only to abdominal exploration. Its chief drawback is the time and expense necessary to thorough examination, but a hasty and inefficient examination is often worse than useless because it may get both patient and doctor into serious trouble.

Finally the diagnosis and treatment may be completed by surgery. I have already expressed my views on the difficulty of healing chronic callous ulcer by medical management, but I want to say that I have no quarrel with those who wish to treat this disease medically if they will treat it thoroughly, rationally and radically. I have no doubt that some ulcers heal spontaneously or that others are cured by careful medical treatment. If I had an ulcer of short duration so far as could be determined, I would try medical means first. But out of respect for the lesion I would withdraw from my affairs and devote myself to it for a period of several months under the constant supervision of a competent gastro-enterologist. These are not cases for ambulatory treatment. I have pointed out the complete insufficiency of clinical guidance. Rest, the maintenance of a high degree of bodily health, the avoidance of acute infections, the control of excess acidity by carefully planned neutralization, the occasional check by the fluoroscope and the radiograph, all are necessary to achieve anything like success. If the ulcer were gastric I would be skeptical of accomplishing anything more than remission of symptoms. If it were duodenal I would be

more hopeful, but prepared for failure and if, after a trial of the above, it became evident that the ulcer had not healed I would repair to a surgeon of particular experience in this line of work, for the medical mortality of ulcer is greater than the surgical, not to speak of the recurring morbidity.

Now briefly as to the present status of surgery. Gastro-enterostomy is not a cure-all and has certain definite disadvantages. In fact, in gastric ulcer there is but little place for the operation. Stomach ulcers should be excised. We have found that gastro-enterostomy often fails to heal them and not infrequently even fails to relieve symptoms. In a percentage of cases these ulcers later become carcinomatous. Local excision and repair is rarely feasible and tends to leave symptom-producing deformity. Destruction by the cautery is better and sometimes the best that can be done in high lying ulcers. Pylorectomy has proved to be best for ulcers in that part of the stomach. Mid-gastric resection and circular anastomosis is often possible for ulcers in the middle of the stomach and the after results are very satisfactory.

Small duodenal ulcers on the anterior wall just distal to the pylorus can sometimes be excised and the opening closed without encroaching on the lumen. This is an ideal operation but conditions rarely permit it to be carried out with safety. More often excision of the ulcer can be combined with gastro-enterostomy in properly selected cases. Most often a gastro-enterostomy is the safest and most promising operation. It yields approximately 90 per cent. of cures. In a few cases relief is not obtained and in a very few, from 1 to 2 per cent., a new ulcer forms at the anastomotic opening. This is a very difficult condition to handle either surgically or medically and is the chief drawback to the operation of gastro-enterostomy. Unfortunately we do not know just what factors are responsible for this untoward occurrence, but it occurs most often in the cases that show the highest degree of acidity and I have a feeling that we shall ultimately come to pyloroplasty or excision of the ulcer in this group.

After operation medical treatment is essential. These cases should be carefully supervised as to diet and general condition. Their freedom from symptoms tempt them to do imprudent things and they need guidance and restraint. It is important to have eliminated oral sepsis before operation as it influences favorably the ulcer itself and makes operation safer. After operation

also the mouth should be kept beyond suspicion of harboring chronic pyogenic foci.

One of the greatest advantages that come to physicians and patient from pursuing an orderly and active plan in diagnosis and treatment of ulcer is the fact that so often the ulcer is found to be imaginary and the true culprit is found in the appendix, the gall bladder, in the pelvis, in rarer intestinal affections or often enough in general infections or other disorders.

The ultimate ramifications of this subject would lead us too far afield. A few words, however, should be given to biliary disease. The normal gall bladder is a useful organ. Together with the sphincter of Oddi which guards the opening of the papilla of Vater; it creates a mechanism which equalizes bile tension throughout the biliary tract and delivers bile into the intestine at the call of digestion. While its storage capacity is not great it has the ability, as shown by Rous and McMaster, to abstract water from the bile with great rapidity so that its storage function is thus indirectly increased many fold. The watery constituents of the bile are absorbed by the lymphatics and are passed through the lymph channels running in the gastro hepatic omentum, coursing along the posterior surface of the head of the pancreas and ultimately emptying into the thoracic duct. The solid and chemical constituents of the bile remain in the gall bladder, giving rise to the dark tarry consistency of the gall bladder bile always noted under normal conditions. At a proper time in the digestive cycle the sphincter of Oddi relaxes and the papilla of Vater opens, allowing the bile from the bile ducts and the gall bladder to trickle into the duodenum. The so-called law of contrary innervation as propounded by Meltzer, states that relaxation of the sphincter of Oddi is associated with contraction of the gall bladder. However, this has never been demonstrated and can be considered as no more than assumption resting on very slender premises. No one has ever seen an empty gall bladder either in life or death unless it had been artificially emptied. There is always a considerable residual. The poorly developed musculature of the gall bladder is adapted only to maintaining a certain tonus pressure and is incapable of anything like complete emptying. Certain substances such as magnesium sulphate are able to act in the same manner as the physiological stimulus of food, relaxing the sphincter and allowing the bile to flow. This has been used by Lyon in his procedure of so-called medical

drainage of the gall bladder. There is no doubt that much bile can be abstracted in this manner and in early and mild cases and in conditions of duodenitis, I believe this procedure can accomplish good. The greatest danger lies in expecting too much of it. We are confronted here with the same risk as just pointed out in the case of ulcer. Gall bladder disease has its ups and downs. Disappearance of symptoms does not mean cure. We have no such means of check up and control in biliary disease as in the case of ulcer for the x-ray is quite as useless in this field as it is valuable in the other. It is true that gall stones are sometimes shown, but a large percentage fail to show and in any event stones are but one manifestation and often not the most important of biliary disease. It should be more thoroughly appreciated that gall bladder infections are extraordinary common and that they begin in young adults. I would recommend to you the recent contribution of Alvarez and his associates appearing in the J. A. M. A., September 22, 1923. Alvarez is a high ranking gastroenterologist, not a surgeon. He says, "Let us think for a moment of the cohort of men and women who are going to have their gall bladders removed in 1924, i. e., 19 years hence. If history repeats itself they must be entering our offices now with their first attacks of more or less marked cholecystitis. One reason why we are not likely to think of that disease is that some of these patients are under 10, some are in high school and many are in their twenties."

Alvarez, though not a surgeon, strongly advocates early operation in these incipient cases. His experience has led him to doubt the permanency of medical treatment. I am not prepared to take so radical a stand. This question still is sub judice. It should, however, be clear enough to any one who will follow his cases and study his surgical pathology that well established gall bladder disease is a condition impossible of restoration to normal, acting as a disturber of digestion, a poisoner of essential organs notably the heart and a potential source of the long array of complications that need no enumeration here. Recent studies of Rose now, Graham, and others have demonstrated that the disease is an infection of the entire biliary tract, not of the bile, though organisms may be present in it just as they are in the urine in bladder and kidney infections; not of the gall bladder alone, though it is usually most marked and most persistent there, but of the walls of the whole branch-

ing system of ducts and the associated lymphatics. As long as the gall bladder remains a nidus of infection, experience has shown that the majority of cases suffer from a continuance of the disease.

I want you to consider one fact in this connection. Fifteen years ago the operation upon the gall bladder most commonly performed was simple drainage—cholecystostomy. The rationale of this operation was that the infection could be relieved by drainage and rest of the gall bladder and it was a simpler procedure than cholecystectomy. When sufficient time had elapsed it was found that many patients, after a period of freedom, again developed symptoms indicative of biliary disorders. The most perfect and complete drainage had failed to restore the tract to normal and insure against recurrence. Dissatisfaction with results led to cholecystectomy as the operation of choice and there is no operation which gives uniformly more satisfaction than the removal of the infected gall bladder provided it is done early enough to escape complications that leave permanent and irreparable disabilities. I refer to pancreatitis, organic adhesions of the stomach and duodenum, biliary cirrhosis and toxic degenerative disease of the heart, kidneys and other parenchymatous organs. Your attention is invited again to the fact that the surgeon has found surgical drainage, which is certainly more complete and efficient than internal drainage, inadequate to the needs of a large group of sufferers from biliary disease. The solution has been shown to be cholecystectomy. In cholecytic disease as in ulcer chronicity means surgery.

1822 Pine St., Philadelphia, Pa.

DIGITALIS AS A STIMULANT.

**By Louis Faugeres Bishop, M.D., Sc.D.,
F.A.C.P.,**

Consultant in Heart and Blood Vessel
Diseases, Lincoln Hospital.

New York.

The earliest description of digitalis spoke of it as a drug which was poisonous and had an emetic and purgative action. Everyone is familiar with loss of appetite, nausea and vomiting that result from large doses of digitalis or any of its related drugs. The man who has never seen any of these side actions has never used digitalis in sufficient doses to get its most beneficial effect.

The nausea of digitalis is different from

other types of nausea in that it is very slow in developing. Large doses of digitalis do not produce an immediate emetic effect such as would happen from those emetics that act directly on the stomach, but the effect happens much later when the drug has had time to reach and influence the central nervous system. So a large dose of digitalis may be followed by vomiting only after a number of hours. The nausea is peculiarly distressing; it lets up and then comes back again and it may recur after being absent for three or four days.

In practice, careful administration of the drug will enable us to stop the medicine before actual vomiting takes place. It is wise, in a serious heart condition, if the person is not used to the drug, to explain the possibility of nausea. I sometimes say: "It may be necessary for you to take a trip across the English Channel before you get well." There seems to be a fair number of occasions where the good effect of the drug on the heart can only be obtained at the same time that the drug effects the stomach. For that reason, if necessary, we must be willing to put up with the displeasure of the person suffering from heart disease and trust that he will forgive us when it is all over and he feels better.

A very important point is that the nausea of digitalis is not due to the local effect of the drug on the stomach, but like sea-sickness, to disturbance of a nervous mechanism that brings on vomiting. We must remember this in the presence of a very sick heart patient with a weak and irritable stomach. Some of these people vomit whatever is put into the stomach and really tolerate digitalis as well as anything else. A weak stomach, if it is the result of poor circulation, is relieved when the circulation is improved. When our prejudice against taking the drug by stomach is great we may substitute some other method.

When digitalis is used in actual practice in pretty full doses we look for some definite effect about the fifth day after we start the use of it. The digitalis crisis occurs about the same time as the crisis of acute lobar pneumonia; usually on the fifth day, sometimes on the fourth, sometimes on the third and sometimes on the seventh. It is hard to say exactly what quantity of the drug is necessary to produce this effect because it varies in different people under different conditions.

A few people are very susceptible to digitalis and a few are very resistant, but the average person acts with a fair degree of uniformity. If we have to give a guess as to the amount of digitalis, distributed over a period of days, required to reach a crisis, we would say from 15 to 30 grains of the leaves, but there will be instances where 50 or more grains may be necessary.

While the emetic effects of digitalis is in close relation to the effect of digitalis upon the heart, nevertheless, they are separate effects and do not by any means always occur simultaneously. Fortunately, many times the beneficial effect on the heart precedes the effect on the stomach. While at other times, it is impossible to get a beneficial heart effect because nausea interferes before sufficient quantity is taken.

A most important point to remember is that nausea is not due to irritation of the stomach. In laboratory work an animal poisoned with digitalis would go through the motions of vomiting even though his stomach has been removed. The vomiting of digitalis is probably not due to the effect of the drug upon the vomiting center, but is a reflex through the sympathetic or vagus nerves from the heart and its appendages. It has been cleverly suggested that in this effect we have a definite proof that this reaction is a reflex protective phenomenon that saves the heart from over-dosage.

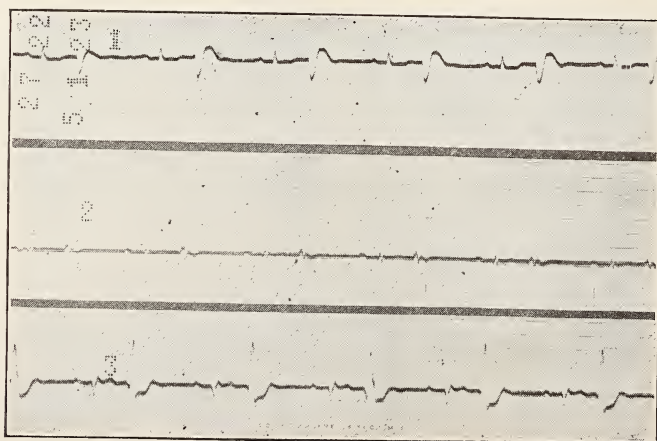
The emetic property of digitalis is a fact that we must accept and no method has been discovered of avoiding it, except at the expense of a reduced dosage. While the emetic effect of digitalis is a

nuisance, it has saved many lives by preventing the abusive use of the drug. The purgative effect of digitalis is not nearly so strong as the emetic effect. It is not often noted clinically, probably because people that have taken the digitalis are not in need of cathartics anyhow, or are taking cathartics already.

The effect of digitalis on the heart muscle: The first effect upon the heart muscle, particularly the ventricle, is to render it more irritable. This is often shown by the appearance of ventricular extrasystoles. If digitalis is given for a long period of time in full doses, in some instances there is a premature contraction following each normal contraction and we get coupled rhythm. Other occasional effects are partial heart block, paroxysmal tachycardia and pulsus alternans.

It is advantageous occasionally to interrupt the use of digitalis in people who take the drug all the time. In the first place we may discover that the person does not need as much as he has been taking, or, on the other hand, when symptoms reappear in its absence the one taking it is re-enforced in his belief of its necessity.

When the pulse is already irregular as in auricular fibrillation, it is impossible to detect the ventricular extrasystoles, except with the electrocardiogram. I do not remember ever to have met with extrasystoles in fibrillation, except in those who were taking digitalis; and in the latter they are quite frequently observed. With the electrocardiogram they are easy to know by variations in the form of ventricular complexes. The bigeminal pulse



Electrocardiogram showing premature contractions and a downward T wave resulting from digitalis.

in people who have been taking digitalis for a long time is an unfavorable sign. It does seem to me that this type of heart beat is particularly apt to be observed in those people who suffer from congestion of the liver and ascites.

There is a kind of rhythm pointed out by Cohn in which the auricle and ventricle beat independently of each other but at nearly equal rates. The auricular impulses are not disturbed, but the auriculo ventricular node assumes the role of ventricular pacemaker, generating stimuli at a slightly faster rate than the sino auriculo node. With this in mind, we can read some electrocardiograms that are otherwise very puzzling.

Perhaps one of the great contributions of modern cardiology in the knowledge of digitalis is the realization that an early effect brings about irritability of the ventricle. This is a much more frequent experience in clinical medicine than any form of heart block.

Depression of conduction of the impulse from the auricles to the ventricles when digitalis is given is probably due to stimulation of the cardio-inhibitory mechanism. The mental picture carried by most clinicians is the effect of the drug upon the tissues of the auriculo ventricular bundle. Here we come once more to the old conflict between the neurogenic and myogenic theory of the heart beat.

The principal therapeutic application of the impulse blocking property of digitalis is, of course, found in fibrillation. It is often a matter of discussion whether digitalis causes fibrillation of the auricle or not. It is a hard question to decide, because the very type of people who need digitalis are the ones who give us the most frequent examples of fibrillation. It seems to be a fact that the continuous administration of digitalis in certain people brings about a continuation of fibrillation which may stop when the drug is stopped. This emphasizes the remark made above that the occasional withdrawal of digitalis constitutes a valuable clinical experiment.

This suspicion that digitalis may be the cause of fibrillation makes a decision more difficult at certain times when the question comes up as to the continuous administration of digitalis in people who are subject to recurrent attacks of fibrillation. Experience is not uniform in this matter. In some people with recurrent attacks of fibrillation it has seemed that

the attacks were of shorter duration and of much less importance when they were under the continuous use of small doses of digitalis. In others the results were not satisfactory in that the attacks recurred with apparently the same frequency and with equal severity.

The examples of fibrillation that are associated with auricular flutter are probably not best treated by the interval use of digitalis. On the other hand, auricular flutter, unassociated with fibrillation, has seemed to be benefited by the continuous use of small doses of digitalis over long periods of time. In the presence of a severe attack of fibrillation or auricular flutter, of course digitalis must be used if it does not come to an end within a reasonable length of time.

A number of observers have reported sinus arrhythmia as resulting from digitalis and McKenzie states that he has seen alternation of the pulse as a result of the drug.

109 East 61st Street.

SYMPTOMATIC VERSUS RADICAL TREATMENT OF INFECTIOUS AND TOXIC NEURALGIA, NEURITIS AND ALLIED CONDITIONS.*

By Pellegrino A. D'Acierno, M.D.,

West Hoboken, N. J.

In a series of well inspired articles, published recently in the "International Clinics," James J. Walsh of New York calls the attention of the medical men to their sad failure to cure what he calls "disuse crippling" or pains lacking a real organic basis, and on the other hand, to the easy success of the unscrupulous healers or ill-trained bonesetters who, perhaps in a modern style, repeat the famous "cures" of Father Hell of Vienna or Dr. Perkins of Connecticut, although instead of magnets or "tractors" they use hands or oscylloclasts.

Undoubtedly you have all heard or read about the miracles done by Mesmer and the wonder cures made by his modern follower Coué. But all this mostly concerns some peculiar psychological conditions which are corrected either by diversion of the mind or other means or tricks apt to deviate the mental trend of the sufferer.

We like, however, to go a step further than that and call the attention of the physicians

*Read before the North Hudson Medical Society, October 29, 1923.

to their sins of omission in handling cases of a subacute or chronic affection which culminate essentially in the phenomenon pain, but are produced by a real cause whose removal will be followed, in due time, by a real cure. To stimulate your interest in the sympathetic study of such affections and in the painstaking attempt to scientifically treat them, is the sincere motive of this paper.

Neuralgia is defined as an affection of a sensory nerve in which pain in the course or distribution of the nerve is the principal symptoms; this pain is paroxysmal and accompanied, or not, with acute secondary symptoms of motor, vasomotor, sensory or secretory nature.

Neuritis, on the other hand, is understood to mean an inflammation of one or more peripheral nerves, be they motor, sensory or sympathetic, at times accompanied by exudates or infiltration of whole cells, but usually by a degenerative process which causes increased irritability of the neurofibrils (hyperesthesia, paresthesia, muscle twitching, etc.) or leads to atrophy (paralysis) in the distribution of the nerves.

Neuralgia and neuritis, however, have almost the same etiology, and the one may change itself into the other. Both may show the same characters (Valleix points, etc.) hence, we cannot always draw a definite line of demarcation between the two, and what we say about neuritis should also, to a certain extent, be referred to neuralgia. The same consideration holds for conditions akin to the aforesaid as perineuritis, causalgia, myalgia, etc.

While a thorough survey of the literature on the subject of neuritis shows a great variety of modes of treatment, nevertheless, it fails to reveal a definite method of radical therapy. The reason probably lies in the fact that neuritis is not a primary disease, but is a symptom or at times a syndrome secondary to diverse etiological factors which, for clearness' sake, we shall attempt to classify in five groups as in Table 1.

As the causes of neuritis are so numerous, the methods of treatment are, naturally, many and different.

When, however, we consider that in the majority of cases, occurring in general practice, neuritis is caused by the action of toxic substances (due either to bacterial life or to faulty metabolism) on the fibers of the peripheral nerves, we feel safe in concluding that the timely removal or elimination of such substances and the restoration of the

physiological activities to the involved nerves would enable us to solve the problem of a radical therapy of toxic and infectious neuritis.

It is the purpose of this paper to describe a new method of radically treating such type of neuritis by means of perineural injections of a synergistic combination of several drugs endowed with alterative, anti-toxic, eliminative and analgesic properties, and which we have tried clinically in over fifty cases.

The formula of such remedy is the following:

Iodine	gm. 0.01
Sodium Iodide	gm. 0.02
Sodium Salicylate	gm. 0.30
Guayacol	gm. 0.10
Camphor	gm. 0.03
Glycerin	c. c. 1.18
Normal Saline Sol.	enough to measure
	c. c. 1.50

It is put up under the commercial name of "Algosan"* in ampules of c.c. 1.50 and in three different strengths according to the varying dose of iodine (gm. 0.005, gm. 0.01 and gm. 0.02 respectively). It appears like a yellow-brown or amber colored fluid, of light oily consistence, having a peculiar odor and neutral reaction. It is almost painless when injected into the tissues.

MODUS OPERANDI:

The technique of the injection varies according to the topography of the nerve or nerves involved. As a general rule, the needle (one of gauge 23 and 1 inch or longer is preferable) is thrust into the tissues surrounding the inflamed nerve, without penetrating the epineurium. This point should be kept in mind especially in treating mixed or motor nerves, to avoid the occurrence of injury leading to motor paralysis.

The points to be injected are those corresponding to the areas more painful to the pressure and ordinarily are indicated by the patient himself, who will either sit down or lie prone and relaxed on a table.

In treating sciatica, as a general routine, we inject the algosan into three areas, one gluteal, one infra-gluteal and one suprapopliteal, corresponding to the homonymous regions.

The infra-gluteal area corresponds precisely to a point where the lower border of the "gluteus maximus" crosses the long head of the "biceps femoris."

*The algosan may be obtained from Dr. P. E. Gallo & Co., Chemists, West Hoboken, N. J.

This point, indicated by Prof. Fandler and used extensively by Dr. Grumbaum, Director of the Institute of Physical Therapy of Vienna, has been selected as the point for deep saline and alcoholic injections of the sciatic nerve; but, as a general procedure, we prefer to give the perineural injections, sitting the tissues around the nerve always tangentially not perpendicularly to the epineurium and consequently avoiding the parenchyma or tissue proper of the nerve.

Another point to be stressed is the rate at which the injection should be made, and that varies from 25 to 30 seconds per 1 c.c. At such rate the injection will prove almost painless. At times, however, the tenderness about the nerve is so pronounced as to compel one to inject only $\frac{1}{3}$ or $\frac{1}{2}$ of the contents of the ampule into each painful area. Following this fractional method, in some instances, we have injected the contents of two or three ampules in the same individual at one sitting; on the other hand, we have met with cases of intense acute pain in neuropathic and very run-down patients in whom the alternative was either to administer some analgesic drug by mouth or inject, as initial treatment, an average dose of morphine and follow thereafter with the injection of algosan. In cases in which the nerve or nerves involved were superficial, like on the antero-internal surface of the tibia or the upper aspect of the foot, we have preferred to inject the gluteal muscles with practically the same results obtained by the perineural method. This observation shows plainly that the "algosan," besides its local analgesic effect has a general antitoxic and metabolic action.

For another subgroup of neuritides, especially those due to tuberculosis or diabetes, besides the general hygienic and dietetic measures, we have adopted a formula of injections in which the sodium salicylate has been substituted by sodium arsenate (average dose gm. 0.001). The effect of insulin on diabetic neuritis has not as yet been thoroughly investigated. In cases of neuritis associated with anaemia, the well-known formulas of iron, arsenic, lecithin, manganese, etc., have been liberally used with very good results, by intramuscular or hypodermic injections. In treating each case, a preliminary step has been, an attempt to remove any "local infection" present.

In tabulating the results obtained by our treatment a case has been considered as final when no relapse had occurred within at least two years from the onset of the infection. Thus we came to the following:

CONCLUSIONS

1. Of four cases of lumbago, two (one rheumatic, the other alcoholic) were cured: One (rheumatic) interrupted the treatment; and one (of anaemic origin) did not improve and required tonic treatment. The end result was 50 per cent. of cures.

2. Of fourteen cases of cervical and brachial neuritis, twelve, due either to rheumatism or influenza, recovered; of the other two, one slightly improved following the injections, but interrupted the treatment; while the other one, undoubtedly tuberculosis (because there was active involvement of the right lung) did not show any improvement after five injections. The result in this class was about 85 per cent. of cures.

3. Of four cases of chronic rheumatic arthritis of the knee, two fully recovered (one after 10 and the other after 20 injections); one improved after five injections; and one did not improve but interrupted the treatment after two injections. That brings the number of cures in this class of cases to 50 per cent.

4. One case of chronic gonorrheal arthritis of right knee completely recovered after twenty injections. Result 100 per cent of cures. Identical result obtained later in other cases of neuralgia, neuritis, synovitis and arthritis of gonorrheal nature, not included in the present statistics, give further support to the above figures.

5. Of the remaining twenty-seven cases, represented mainly by sciatic neuritis, the net result is about 66 per cent. of cures with an average number of 15 injections.

6. In all and every case treated, the number of injections required to effect a cure has been in direct ratio to the duration of disability.

7. In no case any outward symptom or unpleasant after-effect has resulted from the use of algosan. As a matter of fact the patient experiences a general feeling of euphoria due probably to the stimulation of the thyroid by the iodine and salicylates (Bandler) and to the consequent improvement of metabolism.

SUMMARY

By using the injections of algosan in the treatment of neuralgia, neuritis and also of myositis and chronic arthritis, we obtained the following results:

70 per cent. of all cases were cured.

16 per cent. of all cases were improved.

14 per cent. of all cases were not improved.

In this last class, it is interesting to note

that one case was of tuberculous neuritis; one due to carcinoma of the prostate; two due to severe anaemia; one to gall bladder disease (cholecystitis); two to chronic rheumatic arthritis; one to chronic crural neuritis (occupational) one of chronic rheumatic lumbago; one of lumbago due to severe anaemia and general debility; one of cervical neuritis in a neurotic, needle-shy patient; two of chronic rheumatic arthritis of knee; and the last one to brachial neuritis of tuberculous origin.

In the light of such experiences, we entertain no doubt that with a better selection of cases, hereafter, we shall achieve a higher percentage of cures.

COMMENT

Although the method described cannot be considered as specific for the cure of all cases of infectious and toxic neuritis, we feel, however, that it is one of the most rational and affording the larger number of cures (70 per cent.) than any other method so far excogitated and used. Yet there is room for further improvement and this will certainly be brought about by the unrelenting progress of the synthetic chemistry. Nevertheless, our candid opinion is that in the treatment of neuritic affections other supplementary methods as physio-therapy, psycho-therapy and also surgery, when indicated, should be used in order to alleviate the severe suffering and shorten the period of disability caused by some persistent cases whose unfit treatment, either through indifference, uncertainty or neglect on our part, has been until now a reproach to the medical profession and on the other hand a source of exploitation on the part of myriads of drugless physicians, naturopaths, chiropractors, cultists, quacks and the like.

Table I.

ETIOLOGY OF NEURALGIA AND NEURITIS.

I. INFECTIOUS	II. TOXIC
A. General Infections	A. Exogenous
Diphtheria	Alcohol
Influenza	Lead
Pneumonia	Mercury
Tuberculosis	Arsenic
Typhoid Fever	Copper
Puerperal Fever	Carbon Sulphide
Rheumatism	Carbon Monoxide
Syphilis	Tobacco (Nicotine)
Gonorrhea	Aniline Compounds
Disentery	Drugs (Cocaine group,
Erysipelas	Atropine, Aconite,
Measles	etc.)
Scarlet Fever	Pertussis
Parotitis	Malaria
Malta Fever	Smallpox
Actinomycosis	Leprosy

B. Focal Infections

Carious teeth
Pyorrhea alveolaris
Tonsillitis
Sinusitis
Otitis
Mastoiditis
Endocarditis
Bronchitis
Cholecystitis
Enterocolitis
(so-called chronic intestinal auto-intoxication)
Prostatitis
Osteo-arthritis
Adenitis
Cervicitis
Epididymitis
Phlebitis
Thracoma

B. Endogenous

1. Deranged Metabolism
 - Anaemia
 - Leukemia
 - Nephritis
 - Diabetes
 - Uric Acid Diathesis
 - a. Gout
 - b. Obesity
 - c. Adiposis dolorosa (Dercum)
 - Chronic Fatigue
 - Deficient Assimilation
 - Semi-starvation
 - Arteriosclerosis
 - Toxemias of Pregnancy
 - Climacterium
 - Pseudo-gout (Pineles)
2. Avitaminoses
 - Rachitis
 - Pellagra
 - Osteomalacia
 - Keratomalacia
 - Scurvy
 - Beribery (Endemic Tropical Neuritis)
3. Ptomaine Poisoning
4. Animal parasites
 - (Trichina Hookworm, Schistosoma, etc.)

III. TRAUMATIC

A. Accidental

- a. Primary
 - Contusion
 - Laceration
 - Section
- b. Secondary to:
 - Sprain
 - Dislocations
 - Fractures
- c. Obstetric Neuritis or Paralysis

B. Occupational

Writers' Cramp
Housemaids' Knee
Shoemakers' Sternalgia
White-washers' Brachialgia

C. Physiologic

Pressure of the pregnant uterus or Fetal presentation or Fecal impaction on Sacral Plexus

D. Pathologic

Neoplasms
Aneurysms
Hernias
Ganglia
Spondylitis tuberculosa
Spondylitis deformans
Exostosis
Myositis ossificans

DEVELOPMENTAL

A. Congenital

Supernumerary ribs (cervical or lumbar)
Anomalies of Vertebral Column (Heteromorphism)
Genu recurvatum
Congenital Talipes Valgus
Congenital Talipes Valgus
Congenital Talipes Calcaneus
Pes cavus

B. Acquired

Coxa Vara
Coxa Valga
Genu Valgum (knock-knee)
Genu Varum (bow-legs)
Paralytic Talipes Equinus
Paralytic Talipes Valgus
Paralytic Talipes Equinovarus (Club-foot)
Pes planus
Anterior metatarsalgia or depression of transverse arch of the foot (Morton)
Ingrown Toe-nail
Hammer-toe
Claw-toe

Varicose veins
Erythromelalgia
Raynaud's disease
Pressure of exudates
Contraction of Cicatricial tissue
Pressure of a callus
Amputation neuroma

Allux Valgus (Bunion)
Achyllodynia or Achyllo-bursitis
Dental Impaction
Curvature of Spine
Splanchno-Ptoxis
Floating Kidneys

E. Climatic

Altitude
Temperature
Atmospheric Pressure
Winds, Moisture, etc.

V. REFLEX

A. Nervous Diseases

A. Organic

Meningitis, Cerebritis,
Cerebral hemorrhage, Cerebral Abscesses and Tumors
Myelitis, Syringo-myelitis, Tabes, Multiple Sclerosis, etc.
Tumors of the Cauda equina

B. Functional

1. Psychoneuroses (Freud)
2. Actual Neuroses (Freud)
Hysteria, (Hyperesthesia, Visceral neuralgias)
Compulsion Neurosis (Shell-shock)
Anxiety Neurosis (Rheumatic-like pains, Parethesias)
Neurasthenia

B. Diseases of Eye, Ear, Nose

C. Diseases of the Heart (Myocarditis, etc.)

D. Diseases of Blood-vessels (Angina Pectoris)

E. Diseases of Abdominal Organs (Appendicitis, etc.)

F. Diseases of Pelvic Organs (Salpingitis, etc.)

G. Diseases of Genito-Urinary Apparatus (Prostatic disease, Stricture, etc.)

H. Diseases of the Rectum (Hemorrhoids, Anal fissure, etc.)

I. Diseases of the Skin (Elephantiasis, Trophe-dema, Zona, etc.)

J. Endocrinopathies:

Exophthalmic Goitre, etc.
Dysfunctions of Endocrine System (Acromegaly, Dystrophia adiposo-genitalis, Diabetes insipidus, etc.)

INJURIES OF THE EYE.*

By William Earle Chase, M.D.,

Passaic, N. J.

To me the most interesting branch of ophthalmology is the subject of injuries. There seems to be no limit to the number of things that can happen to an eye along the line of traumatism, and no two cases are just alike. By injuries of the eye, is understood all changes in this organ and adnexa, that may be caused by traumatism which may effect its function and appearance through mechanical, thermal, chemical, or electrical forces. The subject may be approached by two methods. The etiologic, and by the anatomic route.

The etiologic gives us a general idea of the injury, while the anatomic gives us a more exact description. All injuries may be classified under 7 heads: 1st, Wounds; 2nd, foreign bodies; 3rd, contusions, concussions, ruptures and dislocations; 4th, thermal and chemical injuries; 5th, combined injuries; 6th, gunshot wounds; 7th, infections.

First as to wounds. Many ocular injuries befall children, and the eye surgeon is frequently called upon to do his utmost to save eyes that have been injured by the perforation by forks, scissors, pens, hat pins, pencils, and all manner of household articles, and parents, nurses and all those who have the care of children should be cautious about children playing with any pointed articles. Those who have read Rousseau's Emile will remember that his idea of educating the child is to let him follow his inclinations as much as possible, but even Rousseau draws the line on letting children play with sharp pointed articles. In the daily routine of the general practitioner he can do much to educate the layman along these lines.

Not a week ago I was in a home and saw a child about six years old cutting paper with sharp pointed scissors. No child should be allowed to use any scissors, except those with the square points. One of the most unusual injuries I have seen happening to a child was caused by a bird that caused a penetrating wound of the cornea with its bill. A boy had caught a Blue Heron on the Hackensack Meadows. He put it in a barrel and covered the top with a board. He warned his little sister, who was of the inquisitive type, to keep away

Dr. D'Acerno has added a very extensive bibliography which would require over 3 1/2 columns more, but we cannot give the space for it, as it is not referred to in the body of the paper by numbers. He has, however, reprints containing it and, if needed by any one, he would doubtless send a copy.—Editor.

Longer Span of Life.—Better care of the health of children during the first and second years of their lives will do much to decrease the death rate and increase the average span of life in the United States, according to a report made by Dr. Herbert Old of Philadelphia. "A white child born today has an expectation of about fifty-five years of life. Twenty years ago he was expected to live only forty-nine years," says Dr. Old. "If all known preventive measures of the present day were put into effect and universally adopted by the public the span of life would be increased to sixty-five years."

*Read before the Passaic County Medical Society, March 13, 1924.

from the barrel, telling her that the bird would pick her eye out, which it came very nearly doing. No sooner had she raised the board than the bird shot out its bill which penetrated the cornea and pulled the iris through the wound. I saw the case about an hour afterward. The anterior chamber was filled with blood so that I could not see the extent of the injury at first. An iridectomy was performed by dead reckoning and much to my surprise when everything had healed I found the lens uninjured and that the vision was 20/15 minus.

Another not uncommon injury usually happening to children while playing with animals, particularly cats, is a wound of the cornea and sometimes other structures of the eye. I once had a case where a cat scratched a little girl on the lower lid, drawing the mucous membrane completely through. Nothing was done about it at the time and when I saw her some time afterward when she was brought to me on account of the unsightly appearance of the lid, due to bright red tissues surrounded by skin. A plastic operation restored the red tissues back where it belonged and some time afterwards scarcely any trace of the injury was left.

Nothing is more interesting than some of the lid injuries and in no class of wounds is there a greater opportunity to use ones ingenuity. While most of them are simple, some are very curious. I remember one where a boy caught his lower lid on a meat hook, which pulled it nearly off. This, however, healed well, leaving little scar tissue. Two months ago I saw a case of a boy who was bitten by a dog that tore the lower lid from the inner canthus obliquely outward as far as the outer canthus, leaving most of the lid hanging loose. This healed nicely, leaving merely a linear scar that in time will be almost invisible. Mostly all of the badly torn lids have been torn away close up at the inner canthus. Often times cutting across the tear duct, causing a watery eye, and a new puncture has to be made by opening the duct farther in, after which probing oftentimes is followed by a beneficial result. As wounded lids are often infected, it has been my practice to sew up the wounds with interrupted sutures of black silk, as one never knows which sutures he will want to remove first, and I never take them all out at once, but take them out as fast as they cease to functionate. The late William H. Thompson states in one of his books, "that he counted the num-

ber of structures that enter into a fit human eye lid and found them to be over three hundred, and that the leaving out of any one of them would spoil the eye, either from a physical or cosmetic standpoint."

In what other part of the body would it be more important to obtain as good a result as possible following an injury? Wounds of the globe vary in every way from a simple wound of the cornea which does not penetrate, to one which passes through into the anterior chamber or beyond. If the anterior chamber is penetrated there is usually a prolapse of the iris or an incarceration. If the iris prolapses or is incarcerated, it is extremely important to recognize it very early. Nearly all the perforating wounds are first seen in the office, at which time it is usually a simple matter to do an iridectomy using a 4% cocaine solution. Very often cases with a prolapsed iris are not seen soon after the injury occurs, or it may not be recognized, if the case falls into the hands of one who is not seeing injury cases every day. As a rule it is comparatively easy to recognize a prolapse or incarceration, as the pupil instead of being round will be elongated or the coloboma will come to a point where it penetrates or has become incarcerated. It is important to trim off the iris as early as possible for as late as 24 hours after the injury it is difficult to replace the edges of the cut iris with the replacer, and after 48 hours there is great danger of getting an infection which may lead to the loss of the entire eye by panophthalmitis.

For a long time I did not follow this rule strictly, and nothing happened. Then I had a case where a child ran some scissors through the cornea producing a prolapse of the iris, which I trimmed off on the fourth or fifth day. The eye was lost any way and I had to enucleate later, and ever since then have felt as if I had not done so the eye might have been saved, leaving only a cystoid cicatrix. When I began doing eye work it was the custom of all surgeons to do a simple cataract extraction. That is without an iridectomy, and in those days it was a very common thing to see a prolapse of the iris, when the case was dressed for the first time. Of course, an iridectomy was performed at once, but in many cases the results were far from satisfactory, and the majority of cases of sympathetic ophthalmia that I have seen have been in cases where cataracts had been removed, in spite of the fact that I had been told that it did not occur following cataract

operations. In fact, in nearly all the cases of sympathetic ophthalmia that I have seen it has occurred where one would least expect to find it; usually in a case where there was a very simple incarceration of iris or capsule. Among the very serious cases, I cannot recall one case. I mean in cases where there has been a large wound involving a considerable extent of the eye. Of course, others may have had a different experience, but this is the experience I have had in following up my cases during the past 30 years.

Consequently, I have become rather conservative about removing injured eyes. One always has two weeks' leeway following an injury anyway, as there are no cases of sympathetic ophthalmia occurring before that so far as I am aware of. The cases which I watch most closely are those where there has been a penetrating wound in the region of the ciliary body. This recalls to my mind an interesting case I treated about a year ago. The case was one where a boy of ten was bending a wire nail which flew up, causing a penetrating wound of the globe just beyond the limbus below. It passed through the ciliary body, just missing the edge of the lens. There was a prolapse of the vitreous. The case was placed in the P. G. H. and the eye kept bandaged and atropine used. There was very little iritis or cyclitis following. I sent him home in about two weeks but continued to keep the case under close observation. About five weeks after the injury, I noticed that he had suddenly developed an irido cyclitis in both eyes and that the sympathizing eye was the most inflamed of the two. At first both pupils were irregular, becoming round later. After four or five weeks the inflammation cleared up in both eyes with 20/15 vision O. U. Since then I have seen him several times and there has been no recurrence of the inflammation. Up to recently, the procedure would have been, in such a case, to remove the injured eye with the first symptoms in the other eye, but of late this rule has not been followed so strictly as it has been found that very often when eyes have not been removed that eventually the vision in the injured eye has been the better of the two.

Foreign Bodies.—Another class of injuries to the eye is that comprising foreign bodies, which go to make up the larger number of injuries, especially in a large industrious center such as we have here. Fortunately, most of them are of a simple nature. If they are small, such as cinders,

cigar ashes, seed capsules and a thousand and one other things blown into the eyes, they are easily removed. While the procedure recognizing their presence and removal is simple yet not always is the best method of removal pursued. It is not uncommon to see one standing in front of another trying to remove a foreign body from his eye. If that is done, you usually stand in your own light. The best method is to work from behind the patient, and better than any operating chair or table is a Morris chair, this also applies to many other minor operations on the eye. In the first place, a Morris chair does not frighten the patient as much as a table, which is of great importance when you are dealing with children or nervous people, for one is not operating under general anaesthesia in these cases. First placing the patient before a window which gives a good light, separate the lids with the thumb and first finger of the left hand placed lengthwise, with the lids, first looking over the cornea with the condensing lens. It is important to examine the cornea, illuminating it from every angle. For most foreign bodies are dark in color and unless you get them in line with the iris, and not in line with the pupil, they may easily be overlooked. If the cornea is clear of any foreign bodies, next evert the lower lid, paying particular attention to the mucous membrane at the inner angle of the lids, and while doing so it is well to examine the puncta, for not uncommonly small hairs which are swept along by the tears attempt to go down into the tear ducts and many times I have seen them sticking out just as the entrance.

Foreign bodies are apt to be found a short distance up under the upper lid. Now sometimes it is not so simple to evert the upper lid, especially in children and persons who are nervous. Of course, it is of the first importance to get around your patient, so to speak and have him realize that if he does what you tell him to that there will be practically no discomfort. As it is almost impossible to evert the upper lid while a person is looking up, first make sure that he is looking down, then placing the ball of the thumb nail downwards over the lid making gentle pressure which will evert the lashes and enable you to grasp them with the thumb and forefinger of the right hand. Then by making a little downward pressure of the thumb of the left hand and lifting up the lashes with the right, the lids will turn on the thumb producing no pain at all. These points may seem mere trifles, but are

nevertheless important, and oftentimes have saved me the trouble of giving a general anaesthetic in the case of a child. If I am looking for a foreign body or removing one at night, I use a 50-watt electric light bulb, mounted behind an oval-shaped reflector, on a handle which connects with the street current by about fifteen feet of cord, and let the patient hold it himself. In no way can one obtain a better illumination. If the foreign body is imbedded in the cornea I use two or three installations of 4% cocaine, removing it with spud. If it is on the surface and not deep, a blunt spud is all that is necessary. If imbedded a flat spud, and in the case of particles of steel, the needle shaped spud. These instruments are much better than attempting to scrape any foreign substance with a knife blade, as I have often seen done. Following the removal of foreign bodies, I always place a dressing over the eye, and that I do before my back has been turned, otherwise the first thing the patient does is to rub the eye with a handkerchief, which is apt to be followed by infections, which if not followed by a serious result, delays the healing. Again a light dressing oftentimes prevents a cocaine ulcer, particularly in cold weather, by preventing the peeling of the outer layer of the cornea. It is surprising, considering the number of foreign bodies that strike the eyes, how few penetrate the cornea. Many of the foreign bodies are of emery and are usually stopped when they reach the deepest layer of the cornea, the membrane of Descemet. It is not uncommon to find small pieces of tool steel penetrating the cornea, and they too are stopped by the tougher structure of the last layer. Sometimes the latter are difficult to remove as they do not break down by scraping with the spud as in the case of emery, and again there is danger of pushing them through into the anterior chamber. At times it is a nice point to decide just how far one is warranted in going. It has been my experience that if there is great danger of penetrating the cornea in using the needle spud, it is wiser to delay the removal for a day or two, and allow the cornea to loosen up around the foreign body, when it is much safer to attempt its removal.

Of the larger foreign bodies which penetrate the globe, most of them are of iron or steel, sometimes copper or glass. These accidents are usually caused by pieces of steel breaking away from hammers or in chipping castings. Most of these foreign bodies strike the eye penetrating the cornea

first, then the iris or lense, and if propelled by sufficient force may pass completely through the eye, but few get beyond the sclera posteriorly. Between the x-ray plate, the localizer and the electro magnet, many eyes are saved today that would have been lost twenty-five years ago. The work of the localizer is little short of wonderful. In a few hours after a foreign body has entered the eye a chart giving the three dimensions of the foreign body in millimeters can be obtained, not only that but its exact size to the 1-50 of an inch.

In the very extensive injuries to the globe where the eye appears hopelessly lost, the question often arises as to whether the eye ought to be removed at once or later. If there has been much loss of vitreous, and the eye is more or less collapsed, it is oftentimes difficult to remove it at once. I think the best procedure is to wait in all cases, for by so doing one can dissect out the ball to better advantage as the muscles can be cut away closer to their attachments, thereby leaving a better notility to the eye ball later, at any rate I have never seen anything go wrong from following this course. Oftentimes in injured eyes when it seems as though the proper course to pursue would be enucleation, the patient flatly refuses, and it is well to not paint the prognosis too black, for very often it will end in his keeping a very presentable looking eye, which will suit him better than having an artificial eye, and artificial eyes have their disadvantages.

I know that many surgeons advise enucleation in practically all badly injured eyes, for fear of sympathetic ophthalmia. But who can point to any one injured eye and say with certainty that if the eye is not removed that the other eye will be lost, so I explain everything as carefully as possible, stating that if the eye is removed during the first ten days that practically all danger is removed, and then to a great extent leave it to him to decide what he wants done about it. If he refuses enucleation I thoroughly impress on his mind that if at any time he has the slightest trouble with either eye to return at once, and in several instances I have had patients return and were perfectly willing to have the eye removed.

Another class of injuries is grouped under the head of gunshot injuries, which includes all injuries caused by firearms of any description. Firecrackers and everything that goes to make up the glorious Fourth. I did not know until recently while

leading the Americanization of Edward Bok, that among the many things that he inaugurated was the "Safe and Sane Fourth," and when I look back on the July 4ths, at the New York Eye and Ear Infirmary, when we usually saw fifty or more cases of injured eyes from the celebration of the day before, cases from simple powder burns to where a person was blinded for life, I feel that Bok rendered a great service to humanity.

The boy may miss a certain amount of fun, but was the game worth the candle? It is a strange thing and surprising how much gunpowder the cornea will stand without breaking down. It is often very difficult to remove it and seldom does any harm when left. I have in mind now a case, one of the first injury cases that I saw in Passaic. A young man looked into the muzzle of a cannon to see why it had not gone off. This was on the fourth of July. He didn't have to wait until the fifth to find out, he hadn't given it quite enough time. It tore away a good part of his scalp, and what force was not expended there was divided up between his two eyes. One eye I had to eviscerate later and the fate of the other hung in the balance for sometime, and finally cleared up with 20/20 minus vision. Fortunately, central vision was maintained, but the cornea still contains many powder grains, which did not prevent him from becoming the head of a large printing house.

Gunshot injuries play queer pranks. I once saw a man who had a quarrel with his wife, placed the muzzle of a revolver to his temple, pulled the trigger and shot away the optic chiasm, leaving him totally blind. In another case, two small children were playing in bed early one morning, and the older one, a boy of ten, found a revolver under the pillow, aimed it at his brother, a boy of six, and he too pulled the trigger. The ball, a thirty-eight calibre, entered the forehead above the brow and passed downward, then turned on its axis and landed in the orbit just above the eye, as is shown in this photograph, which was made by Dr. Terhune. No harm was done to his sight.

Burns.—Another class of cases is represented by the various burns—caused by hot fluids, acids, alkalies, including lime, molten metals, iodine, ammonia, etc. Many of the burns of the eye are caused by carelessness. The family medicine chest or shelf, which is usually kept in the bathroom, is a common source of many mis-

takes. All kinds of medicines and washes knock elbows here, and many without labels. Iodine and argyrol are often kept side by side and I have seen a number of bad burns resulting, though not usually serious, by mixing up the two. Ammonia burns are not uncommon, from splashing it into the eyes or from the toting around of ammonia guns. Chloride of lime, when it has been sealed for some time and then suddenly opened, especially in hot weather, is apt to set up an explosion and burn the eyes.

Another common bathroom mistake is caused by putting away an atropine solution after it has served its purpose, usually for the refraction of children's eyes. Every once in a while some one comes in with the pupils widely dilated and frightened to death, with the usual history that having a sore eye he had used some drops given to another member of the family possibly a year before for a sore eye.

I usually instruct people to throw away the bottle as soon as the treatment of the case is finished, and to empty the bottle first. If a person past middle life, and with a tendency to glaucoma, happened to make such a mistake, such an eye might be lost.

Lime burns are apt to be very serious, if first aid is delayed, and every minute counts. The sooner a 4% solution of cocaine can be installed, and the particles of lime removed by cotton on tooth picks the better, for the particle not only scratches the cornea but continues to slake for some time. If much of it gets into the eye, the lids become oedematous almost at once and the cornea hazy. If the masses of lime are allowed to remain under the lids for any length of time it may burn deeply, causing a considerable amount of cicatricial tissue, resulting in symblepharon, entropion or corneal cicatrices, causing loss of vision. Molten lead at times flies into the eyes, especially if poured on a wet surface or when water is thrown on it. I have seen cases when it has soldered the lids up tight so that the lashes had to be trimmed off with scissors. In one case I was able to lift out a cast of the globe and yet no harm was done. It is impossible to go into the treatment of burned eyes at this time. Prevention is the most important part of the treatment and that will come about by educating the public to be more cautious.

Infections following the treatments of the eye are very common. Oftentimes the slightest abrasion of the cornea may be followed by the most serious results. It is

surprising that these results do not occur oftener when one considers the carelessness with which foreign bodies are removed. In these days when so many industrial plants have nurses who render first aid, the number of cases of infected eyes from the removal of foreign bodies is becoming fewer in number. In many mills one finds some "handy man," as he is called, who removes foreign bodies from the eyes. He usually uses a match stick, or the first thing that comes handy, without any attempt at sterilizing it. With every precaution eyes may become infected, and there is no reason for being careless about antisepsis. There is no reason why every instrument used in removing foreign bodies should not first be dipped in boiling water, and then placed in alcohol. I have formed the habit of placing the spud in alcohol before cocainizing the eye, and then I do not forget to do so. Immediately after removing a foreign body a light dressing should be placed over the eye with $\frac{1}{4}$ adhesive strip holding it, and the patient should be told of the danger of rubbing the eye with a handkerchief or even with his hands unless they have been thoroughly washed.

When one considers that an infected ulcer of the cornea always leaves some cicatrical tissue and if it is directly in the center of the cornea it means a marked drop in vision with a possible disturbance of binocular vision, should we not take every precaution. If there is a commencing infection either with the foreign body or after it is removed, the ulcer should be scraped out and touched up with iodine. One should ever be on the lookout for pus in the anterior chamber when there is an infection and its presence noted early. As it gravitates, it will be found earliest when we examine the eye when the patient is looking down as far as possible. By observing this rule pus can be recognized that would be overlooked if he were looking straight ahead or upwards.

Not long ago I saw a man who had an infected eye, and in talking with him found that at the place where he worked that a bottle of Collyrium was kept standing where any one who had a sore eye could go and use it. As you know a collyrium bottle has an eye cup stopper, and I asked him if they ever sterilized the eye cup, and he said that he did not believe they ever did. Could there be any better method for spreading infection?

Splendid work is being done to lessen the number of injuries to the eyes, as well as

to other parts of the body. A number of times I have spent a very profitable hour or two at the American Museum of Safety in New York, where all kinds of devices to prevent accidents are on exhibition, and in addition to this lectures on the subject are given daily. In most industrial plants, where foreign substances are apt to fly into the eyes, goggles are kept and the operatives instructed to wear them, but I find that it is not generally enforced. About a week ago I was much interested by what I was told by a man from whose cornea I had just removed a foreign body. He had come to Passaic from a town in Pennsylvania where they employed seven thousand men, and that they were compelled to wear goggles. It was one of his duties to go about among the men and see that the rule was obeyed. If anyone was found without them he was layed off for 10 days. In talking with metal workers, I have found that they all object to wearing them on account of the annoyance of keeping them clean. Only drastic enforcement of the rule will make them do so.

Goggles today are made which not only protect the eyes from flying particles or worse, but which cut out the ultra violet and infra red radiations.

ORTHOPEDIC CAUSES, LOWER BACK PAIN*

By Barclay W. Moffat, M.D.,

New York.

It is well known that lower back pain may be due either to visceral lesions—as a rule in the pelvis—or to local conditions in the back itself. These two principle causes are not infrequently confused and it is my intention to discuss briefly the various conditions in the latter class.

To differentiate these from the former class, it is necessary that there be present some signs or symptoms other than pain in the region under consideration. These manifestations may be (1) tenderness; (2) spasm; (3) limitation of motion, and (4) deformity. In discussing the differential diagnosis, for convenience I will take up the subject under the various structures affected, that is, the muscles and the bones and joints, including fractures. Nerve pain in this region, is always secondary to affection of one or the other of these struc-

*Read at the Meeting of the Monmouth County Medical Society.

ures and therefore will not be considered separately.

In the cases of the muscles, there may be a true myositis evidenced by tenderness, pain on use and occasionally spasm with a consequent limitation of motion in the joints operated by these muscles. The most common example of course, of this is called lumbago by the laity, in which the erector spinae muscles of the lumbar region are affected.

A less commonly recognized condition is gluteal myositis. Here, the pain is referred to the mid point of the lumbar sacro region and the true nature of the affection is recognized only by the evidence of tenderness over the origin of the glutei, usually on one side although occasionally on both. The gluteus most occasionally affected is the medius and occasionally the minimus but never the maximus. Often with this is associated a similar condition in the tensor fascia femoris evidenced by tenderness on pressure at the anterior superior spine. These conditions are occasionally accompanied by secondary sciatic neuralgia. The purely traumatic affection of muscle fibres cannot be distinguished from the true myositis except by a history of a sufficient injury and of less chronicity in these cases. Flat foot can be properly included in this category as it is a common cause of similar signs in these muscles.

The bones and joints in this region may give rise to symptoms in various conditions. Most common of all is probably the rheumatic type of spondylitis. Here, as in myositis, there may be spasm and limitation of motion with or without tenderness. There may also be root pain caused by secondary irritation of the spinal roots. Tuberculous spondylitis presents a similar picture, but the signs are manifested over a much lesser region of the spine, by the appearance of a knuckle formed by necrosis of the bodies of the vertebrae and their subsequent collapse on weight bearing. The condition may be brought to mind only on the appearance of an abscess, usually in the psoas region, or possibly in the lumbar region at one side of the spine. Both these conditions in their various stages can be diagnosed positively only by x-ray. Typhoid spondylitis is so uncommon that it scarcely needs to be mentioned. It results often in the formation of a knuckle, though x-ray shows no destruction of the body of the vertebrae as in tuberculosis. Sciatic scoliosis is not a clinical entity but is a term used to designate a spinal curve associated with

spasm of the erector spinae muscles on one side and sciatic neuralgia. The cause is usually a myositis though it may be any one of the various lesions in this region which gives rise to sciatic neuralgia. Displacement of the sacro-iliac joint is not a common cause of pain in the lower back. Rarely though there may be an actual luxation as a result of trauma. Occasionally a simple sprain of the ligaments of these joints is met with, and most rarely of all there may be actual disease present, such as tuberculosis arthritis.

Spondylolisthesis is another condition in this region giving pain in the lumbo-sacral region and is usually associated with a secondary sciatic neuralgia. This occurs usually in heavy subjects in whom the lumbar lordosis is already exaggerated. There may or may not be a history of trauma sufficient to account for the displacement of the fifth lumbar vertebrae of the sacrum. There may be simply a sprain in this joint in case where the lower lumbar spine is more horizontal than normal. The x-ray of course, will show this condition as well as the actual displacement if it be present. Clinically, pressure over the spinous process of the fifth lumbar will give pain locally as well as along the sciatic nerve if a neuralgia here is also present. The lumbar sacral joint presents deviation from the normal in a great number of cases and this deviation may result in structural weakness or improper function. A relatively uncommon example of this is the so-called sacralization of the fifth lumbar in which abnormally developed transverse processes of this vertebrae impinge on the iliac wings. This diagnosis can be established by an oblique view of the region. A more uncommon condition is the low assimilation pelvis in which the first sacral segment corresponds in structure to the lumbar vertebrae and whose transverse processes make up the upper half of the sacral portion of the sacro-iliac joint. This allows abnormal mobility in this region and sprain of the joint results. Fracture of the vertebral bodies is more common than is recognized in general practice and should be suspected in cases where trauma has "jack-knifed" the spine. There will be a persistent pain, spasm, limitation of motion, tenderness and later the appearance of a knuckle. There will be no involvement of the cord or nerve roots, in at least one-third of the cases. Fracture of the transverse processes may be caused by direct injury or by muscle pull and will

give the same picture, except for the appearance of the kunckle. The coccyx is not an uncommon site of fracture, usually the result of direct trauma. The sacro-coccygeal joint may be the seat of arthritis which will give a similar clinical picture. The diagnosis in these cases will be established by x-ray and by rectal examination.

County Medical Societies' Reports

BERGEN COUNTY.

Frederick S. Hallett, M.D., Reporter.

The Bergen County Medical Society held a joint meeting with the Rockland County, N. Y. Medical Society on May 7th, at the Lederle Laboratories, Pearl River, N. Y.

The program included an inspection of the various departments and special demonstrations of the work carried on there. This was followed by the scientific session, when we listened to an exceedingly interesting address by Dr. William H. Park of New York City, subject: "Preventive Measures in Diphtheria, Scarlet Fever and Measles."

CAPE MAY.

(From the North American, Phila.)

At the meeting of the Cape May County Medical Association, held in the Great Egg Harbor Inn, at Beesley's Point, a resolution was adopted setting forth that the county association go on record as favoring a Cape May county hospital, and authorizing the president to name a board of chosen freeholders to bring about its establishment.

President Colonel Charles M. Gandy, of the county association named the following committee: Drs. W. P. Haines, Ocean City; Julius Way, county physician, Cape May Court House, N. J.; H. H. Tomlin, Wildwood; Frank R. Hughes, Cape May and C. W. Way, Sea Isle City.

The discussion on the county hospital was opened by an address by Director Joseph G. Champion of the board of freeholders, who stated that the freeholders realized the need of hospitals, particularly for emergency cases, but as business men were at a loss to know how to handle the situation in Cape May county, as it was purely a medical one, and that he hoped the doctors of the county would express themselves for the guidance of the freeholders. At the present time, he stated, there were appropriations made each year to Mace's Hospital, Wildwood, and Scotch Hall, Ocean City, but that the freeholders had no way of knowing what return the county was getting from these appropriations, or whether they were too large or too small for the services rendered by these institutions.

The remarks of Director Champion were followed by Freeholders Robert J. Kay and Charles E. Foster, who asked the help of the county association in deciding this question.

After some discussion of the matter, the resolution was adopted. All speakers favored the plan of a county hospital and dwelt upon its need at once, and favored the location of the institution at Cape May Court House, the

geographical center of the county. Dr. Mace of Mace's Hospital, Wildwood, stated that she treated a great number of accident cases at her hospital, and the appropriation from the county did not begin to meet the cost of the public service given, for which there was no other compensation. She favored, she stated, the establishment of a hospital, and would then turn her hospital into a private institution.

HUDSON COUNTY.

Wm. Freile, M.D., F.A.C.S., Reporter.

The regular monthly meeting was held on May 6, 1924, at the Jersey City Hospital. The meeting was called to order at 9 P. M., Dr. Kelley, president, in the chair.

Bills for printing and supplies were ordered paid, and also flowers for Dr. Broderick's funeral.

Regularly moved that Nominating Committee be appointed to nominate delegates. Seconded and carried and Drs. Quigley, Swiney and Perlberg were appointed. After much discussion it was regularly moved by Dr. Quigley that the delegates to the State Society meeting at Atlantic City be instructed not to vote in favor of Dr. McAllister, due to his antagonistic attitude to the medical profession at the last Legislative session. Dr. Quigley stated that Dr. McAllister was out of harmony with the rest of the State Society and should not be advanced to the presidency. Motion was seconded.

Dr. Kelley said that he felt it was a mistake to do this, as Dr. McAllister had been a member of the State Society for thirty years and only expressed opinion of the State Board of Medical Examiners and not his own personal opinion, and that he had subsequently prevailed on the State Board to withdraw obnoxious bills. Dr. Kelley said that delegates should go uninstructed and then form opinion at the meeting. Dr. Cosgrove stated that he should be either on State Board of Medical Examiners and not President or vice versa. Dr. King endorsed opinion of Dr. Quigley. Motion carried.

New members elected: Dr. M. Linden and Dr. Ed. Peters of Jersey City.

Building Committee: Dr. Yeaton moved that the Hudson County Medical Society buy piece of property mentioned in Dr. Cosgrove's report. Seconded. Dr. Lange of North Hudson stated that the men of North Hudson are not in favor of this and would not support Academy of Medicine on this site as they objected to it. Dr. Kelley stated that he felt Academy could be put across, but if the society was against it as expressed at the meeting, then it would fall flat.

Dr. Nevin moved that Building Committee be discharged. Seconded and carried. Delegates to the State Society: Permanent, Drs. G. M. King, Von Duesten, E. F. Yeaton, R. L. Ballinger, C. V. Niemeyer, E. J. Luippold, W. T. Callery, M. A. Swiney. Alternate, permanent, in place of Dr. Broderick—Dr. H. J. Perlberg: Alternate, permanent, Dr. L. C. Lang—Dr. Wm. Pinkerton.

Annual Delegates: Drs. T. J. Kiegan, P. A. Naias, M. N. Sullivan, A. V. Piskorski, A. E. Jaffin, Edmone Daly, Henry Klaus, John Rutnaver, A. G. Sacco, H. F. Tidwell, Geo. Ginsberg, James Londrigan, Ernest Thum. Alter-

ates: Drs. Wm. Brooke, W. L. Williamson, A. Nelson, Emily Rundlett, and Frank Pearlstein.

The paper of the evening on "Physiotherapy" by Major Sampson, and was illustrated by 6,000 feet of film. This will be published at a later date.

SOMERSET COUNTY.

David S. Renner, M.D., Reporter.

A special meeting of the Somerset County Medical Society was held at the New Jersey State Village for Epileptics at Skillman, May 15, 1924, at 2.30 o'clock.

A short business session was held, during which Dr. Launcelot Ely was elected Annual Delegate to the State Medical Society to complete the quota. Dr. A. H. Lawton was elected Annual Delegate to fill the vacancy caused by the resignation of Dr. Ely.

Dr. David F. Weeks, Superintendent of The Village, welcomed the visitors, and read a paper entitled, "Some Phases of Epilepsy." This was followed by a clinic, conducted by Dr. Dan S. Renner, assisted by the staff. Several interesting cases were presented, among which was a case of ainhum in a white female.

Members of the Mercer, Middlesex, Bergen and Hunterdon County Societies were also guests of The Village.

Dr. Edward S. Hawke, and Dr. D. C. English addressed the meeting.

The Village was inspected by the visitors, and the meeting concluded with a buffet luncheon.

Middlesex County Recreation Council.

The Middlesex County Recreation Council assembled at a luncheon meeting at the Hotel Klein on Wednesday, May 7th, completed their final plans for the operation and financing of children's camp for the summer. The camp, as was explained by the president, Dr. Chas. I. Silk, will be opened for the undernourished children of the county. The camp will accommodate one hundred children at a time. These children will be selected by local committees from every community who will represent the various organizations in the county. Each child will be required to present a physician's certificate, stating that he is free from contagious disease and a proper subject for treatment at the camp. The camp is not designed as a vacation camp where children may stay one or two weeks, but is a place where an undernourished child may stay until he is restored to normal health. Under this plan some children may stay three weeks, while others may stay six weeks or the whole summer.

The chairman explained that the Recreation Council was a federation of all the existing civic, fraternal and social organizations in the county, and that the organization had been legally incorporated and approved by the Committee of Institutions and Agencies. The initial financing of the camp will be met by contributions, in the form of memberships, from the organizations in the county. About the first of June a campaign manager will be taken on by the Council to interview and interest organizations and limited groups of people. The architect for the camp, Mr. Aylin Pierson, spoke of the desirability of the site, abundant water supply, its accessibility for trades peo-

ple and visitors, and the comparative ease of drainage. The buildings are to consist of a combination recreation hall and dining room with a big fire place and movable tables. At one end of this large room will be the kitchen and service rooms and at the other end the administration office and dispensary. The lumber for building the camp is to be supplied by the lumber dealers of the county and the five organizations of carpenters in the county have agreed to volunteer their services for putting up the buildings.

Representatives from some of the local carpenters' unions were present at the camp and spoke of their favorable attitude toward the enterprise. Mr. Harry Medinets, counsel of the Middlesex County Recreation Council, told of the co-operation of the County Board of Freeholders in extending to the Recreation Council a lease for the property on which the camp is to be erected. The lease is for a period of five years at a nominal rental of fifty dollars a year. The site comprises two hundred and eighty acres of land and is in the borough of Menlo Park, immediately adjoining Metuchen. The purpose of the Council, as stated in the incorporation papers, was also read by Mr. Medinets.

The purposes for which this corporation is formed are: To foster and promote in every way the interest and welfare of all the people of Middlesex County, regardless of race, color or creed, and all things relating to social, moral, mental and physical benefit. To foster and promote interest in the creation of public parks and recreational centers in Middlesex County, New Jersey. To maintain and support recreational centers for the physical development of children; to develop throughout Middlesex County opportunities for play and recreation, for social expression and promotion of physical health and mental and normal well-being among all classes and groups of people, but particularly among children and growing boys and girls mal-nourished or poorly developed.

It is purposed to open the camp about the middle of the summer. Details of personnel and management have not been fully decided, but the camp will be in charge of a trained camp director with a staff of counsellors and a corps of attendants. A nutrition diet will be arranged for the children. A graduate will be resident at the camp and have charge of the dispensary. An important step in enlisting official support was made when the Mayor of New Brunswick, John J. Morrison, was made official treasurer of the organization. The other officers of the organization are: Dr. Chas. I. Silk, president; and Miss Jane J. Packard, secretary.

Local Medical Societies

Staff of the Atlantic City Hospital.

The staff held their March and April meetings at the Breakers Hotel. At the April meeting Dr. Walt P. Conaway reported his gynecological service and Dr. D. W. Scanlan reported his medical service. Both chiefs discussed the important points of the service and discussed the deaths. Dr. Joseph Poland, associate in medicine, read a paper on pyelitis and reported three cases. Dr. Grunic, a

member of the interne staff, reported from the medical service, a case of spinal cord lesion which was caused by a fracture of the cervical vertebra caused by a slight fall of five feet from a step ladder; the patient not experiencing sufficient discomfort to seek treatment until two weeks after the accident. Resulted fatally.

Dr. Thomas Taggart reported at the April meeting his surgical service with discussion of the important points and deaths; and also reported a series of intestinal obstruction cases. Dr. Richard Bew, medical director, reported in full, a case of a rare condition, gelatinoid carcinoma or colloid cancer of the peritoneum. This was metastatic from a colloid gastric ulcer.

Dr. Homer Silvers and Dr. James Mason reported, from Dr. Silvers' surgical service, the following cases: (1) Ruptured illium in a young man, and caused by the patient falling stomach downward on the railing of a fence. Recovered; (2) a tear of mesentery of transverse colon, caused by a wagon loaded with railroad ties running over his abdomen. A slight injury for an obviously severe accident. Recovered. (3) Removal of stone from that point of the right ureter lying in the pelvis; this was done extraperitoneally through an anterior abdominal incision. Recovered.

Bayonne Hospital Staff Meeting.

The Clinical Society of the Bayonne Hospital Staff was held May 6th.

From Dr. Donohoe's service, the following cases were reported and discussed. 1st—A case of fracture of the 1st, 2nd and 3rd ribs and right clavicle which was complicated by traumatic pneumothorax and internal hemorrhage. Death occurred in a few hours; 2nd—A case of fracture of the left parietal bone from an automobile accident with a history of having been hit by two autos in a space of a few hours; 3rd—A case of fracture of both femurs with severe laceration of left groin followed in three days by fat embolism. In this connection Dr. Klugman reported a case of fracture of the clavicle and the 1st and 2nd ribs which was followed three days later by a fat embolism.

From Dr. Dearie's service, a case of pneumonia involving the right middle and lower lobes, with delayed resolution and the formation of an empyema interlobar in type and situated between the lower and middle lobes on the right. This case was complicated by an intractable diarrhoea which was not apparently due to typhoid, para-typhoid or any parasitic organism. The only bacterium present in the feces being a bacillus akin to the lactic acid producing types.

Dr. Forman reported a case of perforated, chronic indurated ulcer of the duodenum, on which he operated with good results. He located the minute perforation by giving the patient some methylene blue before the operation and looking for the stain on opening the abdomen.

From Dr. Riha's service, a case of developmental anomaly. An autopsy showed double cleft palate and hare lip, clubbed feet, rudimentary penis, scrotum resembling the labia majora of the female, no testes, with the internal genital organs undeveloped and in the

stage of indeterminate development corresponding to the 4th to 6th month of fetal development. He also reported a case of pylorospasm which was treated with good results by so-called dry farina feeding.

From Dr. Woodruff's service, a case of bilateral renal calculi demonstrated by the x-ray. He removed the stones from the right kidney and expects to remove those in the other kidney in a few weeks.

Dr. Frank reported a case of congenital dislocation of the hip. So it was diagnosed by a number of orthopedists from the history and character of the gait and movements. X-ray showed that there had been a complete erosion of the head of the femur as well as the neck of the same and the cup of the acetabulum. He thought that this condition had come about early in the life of the patient and that it was in all probability due to tuberculosis.

Jersey City Hospital Staff.

A regular meeting of the Hospital Staff was held in the hospital March 13, 1924. Presiding, Dr. S. Cosgrove.

The first case was one of Hodgkins disease, presented by Dr. A. P. Reiman. The doctor outlined the history of the case and stated that the child had been treated by a physician for whooping cough and that the intense cough which she had was not unlike the spasms noticed in whooping cough cases, although the child did not whoop. There was considerable swelling on the left side, which increased in size at times of extreme exertion and after complete rest decreased somewhat. The child appeared to be well nourished; a slight tenderness noted in the abdominal region. The case was treated by Dr. Axford by x-ray and the results obtained to date have been more than satisfactory, the swelling having decreased, the neck measurements having gone down from 13¼ inches to 12 inches after three treatments. Dr. Binder discussed this case.

Dr. A. E. Jaffin presented three cases of tuberculosis in children and outlined the degree of infection in each case. The first case was four years of age, the mother having died of tuberculosis four weeks previous to Dr. Jaffin's case of the child. This child had been exposed practically all of its life. When the child was first examined, the history was rather misleading, several possibilities being considered, such as typhoid, malaria and pyelitis. However, all of these were ruled out. Then after a day or two of observation, and negative findings, Dr. Jaffin decided to have x-ray taken with the hope that it might disclose something. He was more than surprised to get such positive evidence of tuberculosis. The child was losing very rapidly and within a month it died. Another child in the same family, five years of age, a boy, fairly well nourished, showed practically nothing on physical examination; only on two occasions did he have a temperature above normal. X-ray examination of this boy disclosed a positive case of tuberculosis but he had the advantage of three or four years of life before his exposure so that his condition was not nearly so serious as that of the younger child. At the present time the boy is coping with the disease very well. Efforts are being made to

have the boy admitted to a preventorium. The third child of the family, eight years of age, looks like a practically well child. X-ray of her chest shows absolutely nothing, but she is suffering from a very marked intestinal tuberculosis. The child has had a greater advantage than any of her family. Dr. Jaffin explained that his object in presenting these cases was to point out the danger of exposing children to tuberculosis and the wisdom of following out a history of tuberculosis in the home in the treatment of children's diseases. Dr. Pollak discussed these cases.

Dr. Warren J. Coleman of New York City, gave a most interesting and timely talk on "High Blood Pressure." He was of the opinion that while the study of blood pressure added something to the medical armamentarium, there was yet much to be learned about it. As an example of this, there are certain conditions under which the diastolic pressure entirely disappears on attempting to read it, the cause for which is not entirely known. Furthermore, should the systolic reading be taken on the rise of the mercurial column, or on its fall. This was not fully decided. More attention should be paid to the relation of the pulse pressure rather than the systolic and diastolic taken by themselves. He stressed the point that blood pressure should be only considered as one factor; that many people carried blood pressure of 200 and over without symptoms for many years. He decried the fact in many instances too much importance was placed on the pressure and as a consequence, certain types of patients lived with the sword of Damocles hanging over their heads.

In certain cases with distinct clinical evidence of high pressure, and the reading comparatively low, he was of the opinion that these cases were much more to be feared than in the type which showed a scale of reading commensurate with their phenomena. He believed that with patience and experience one could very reasonably judge the pressure by palpation. He discussed the various causes of high blood pressure; he believed that where it was related to kidney lesions it was conservative process as it had been shown that these cases did not feel so well when the pressure was lowered by artificial means. He referred to the influence of nerve tension affecting the pressure.

While many theories have been advanced to account for increased tension at the present time, the most reasonable hypothesis was to assume its relationship to the gastro-intestinal tract and even although in enteroptotics blood pressure was usually low, he did not feel that this vitiated his argument as the toxemia might in one case produce high, and in certain conditions in another case, a low blood pressure. In the line of treatment he advised a reduction of the protein intake with an occasional use of one of the mercurials, and a correction as far as possible of any entourage methods of living. He believed that in the near future physiological investigation with perhaps a tube inserted directly into the blood vessels, will help to clear up some of the present discrepancies.

The talk evoked a full discussion by Drs. Street, Jaffin, Nevin, Friel, Londrigan, Rector, Rietnauer, Reiman and Cosgrove. Dr.

Coleman replied to the questions of each of the men. At the conclusion of Dr. Coleman's remarks Dr. Cosgrove, on behalf of the Medical Directors of the Hospital and the members of the staff thanked Dr. Coleman and informed him that it was more than a pleasure to have him as their guest and that they had enjoyed his remarks to the utmost.

The hospital report for the month of February showed that there were 757 patients admitted during the month, and that with 40 remaining from the previous month, 1,197 were treated. 735 patients were discharged during the month, 270 cured, 340 improved, 5 unimproved, 36 transfers to other institutions and 84 died. There were 926 new cases, and 1,551 revisits in the dispensary, and 926 emergency room treatments, and 745 ambulance calls.

There were 133 major operations, 157 minor operations and 30 T. & A. operations.

Summit Medical Society.

William J. Lamson, M.D., Secretary.

The annual meeting of the Summit Medical Society was held at the Canoe Brook Country Club May 29th at 8.30 P. M. In the absence of the president and vice-president, Dr. Clark was elected chairman pro tem. Present: Drs. Alexander, Bensley, Bowles, Clark, Dengler, Falvello, Krauss, Lamson, Meeker, Meigh, Milligan, Morris, Reiter, Smalley, Tidaback and Wolfe; and as guests, Drs. Byington and Disbrow of Summit, and Clark of Madison.

Dr. N. W. Burritt of Summit was elected a member of the society.

The following officers were elected for the coming year: President, Dr. H. H. Bowles; vice-president, Dr. R. D. Baker; secretary and treasurer, Dr. W. J. Lamson.

The paper of the evening was read by Dr. Harold Corbusier of Plainfield, on "Physiotherapy in the Treatment of Orthopedic Diseases." He emphasized the importance of this method of treatment in both operative and non-operative cases, and before as well as after operation. He described the various means of physiotherapy, such as massage, electricity, baths, diathermy, special exercises, etc., and the very excellent results which can be obtained were illustrated by lantern slides.

Other Medical Organizations

Rockland County, N. Y., and Bergen County, N. J., Societies' Joint Meeting.

On Wednesday afternoon, May 7, 1924, the spring meeting of the Rockland County Medical Society was held in Pearl River at the Lederle Antitoxin Laboratories. Dr. R. O. Clock, who is again president of the Society this year, invited the Bergen County Medical Society of New Jersey to join this meeting. Ninety-one physicians attended the joint meeting.

Special demonstrations showing the processes in the manufacture of Bacillus Acidophilus Milk as well as the production of diphtheria toxin-antitoxin mixture and anti-hog cholera serum were given in the various departments of the laboratories.

At the scientific session, the speaker of the day was Dr. William H. Park, who is director of the Bureau of Laboratories of the New York City Department of Health and president of the American Public Health Association. Dr. Park's address was intensely interesting and proved to be a rare treat for he discussed the latest developments in preventive measures for diphtheria, scarlet fever and measles. In recognition of their appreciation of Dr. Park's address, a rising vote of thanks was tendered Dr. Park and the Rockland County Medical Society elected him an honorary member.

(We expect to insert Dr. Park's address in next month's Journal.—Editor.)

At the business session of the Society, the following resolutions were unanimously adopted:

Whereas: The Medical Society of the County of Rockland notes with marked apprehension and concern the steady and continued increase in the number of reported cases of diphtheria within the State of New York (excepting New York City), and this notwithstanding the administration of diphtheria antitoxin in increasing amounts each year, and

Whereas: The medical profession now has at its command a safe, reliable and efficient method of producing active immunity against diphtheria in the majority of persons by means of subcutaneous injections of diphtheria toxin-antitoxin mixture, the immunity lasting for life in the majority of cases so far as present statistics show, and

Whereas: It is a well-known fact, recognized by all physicians, that infants and young children, especially those under ten years of age, are particularly susceptible to diphtheritic infection, and it is in this age period that the morbidity and mortality rates are highest; therefore be it

Resolved: That it is the unanimous opinion of this Society that active and energetic steps should be taken by the physicians and the school authorities of Rockland County to bring to the attention of the general public, and especially to the attention of the parents of young children, the great value of diphtheria toxin-antitoxin mixture, which is a thoroughly tested aid to preventive medicine; and to urge parents to permit this protective measure to be given to their children, as has been so successfully carried out among thousands of school children and pre-school age children in New York City, Auburn, Syracuse, Seneca Falls and Port Henry;

Resolved: That the president of this Society be requested to immediately bring to the attention of all health officers, school physicians, boards of education and parent-teachers' associations, as well as all nurses engaged in public health or school work, within the County of Rockland, these resolutions, with the request of the Society that they aid in the furtherance of this work; and also that the medical and lay press be requested to publish these resolutions.

After the meeting, the societies adjourned to the Lederle luncheon where a bountiful supper was served. The room was prettily decorated with festoons of yellow, which is the Rockland County Medical Society's color. Eighteen girls dressed in snowy white, employees of the Lederle Antitoxin Laboratories acted as volunteer waitresses and proved very capable and efficient.

(The Editor of the Journal, by invitation of Dr. Clock, attended this meeting and found it to be exceedingly interesting and instructive.)

The Middlesex College of Medicine and Surgery.

A report of the investigation of this college by the Connecticut Special Grand Jury is a scathing indictment of this institution and should prompt the Massachusetts Medical Society to deal with those of its members who are aiding and abetting the maintenance of a medical school which is severely condemned by a judicial body of a sister State. If the college is inadequately equipped and does not maintain a teaching service in conformity with its published claims it is securing students under false pretences, and hence is not in the class

of honorable medical organizations. This condition can be dealt with effectively if the society is disposed to act. Since the charges have been made public it is the duty of the society to ascertain whether those of its men who are supporting this school are entitled to fellowship in the society.

The time has come when it should be determined whether the society stands for ethical standards in all matters pertaining to medicine. If, on investigation, it is found that the conduct of the faculty of the Middlesex College is above reproach, there is nothing to be said other than to disagree with the Connecticut Special Grand Jury; but if investigation shows that students are induced to enter the college and pay the required fees through fraudulent claims there would seem to be only one course to pursue. Unless action is taken, the society may be regarded as indifferent to the behavior of its members so far as condemnation by a judicial body tends to show dishonorable conduct.—Boston Med. and Surg. Bulletin.

American College of Surgeons.—The Clinical Congress of the American College of Surgeons met in Trenton on May 5th. A reception was given under the auspices of the Trenton Chamber of Commerce at the Stacy-Trent. Dr. B. Van D. Hedges of Plainfield presiding and Mayor Donnelly giving an address of welcome. Four addresses were given. Dr. Allan Craig of Chicago, associate director of the American College of Surgeons, spoke on "The American College of Surgeons and Better Health." Dr. Malcolm T. MacEachern of Chicago, also an associate director of the college, spoke on "The Care of the Sick." "Scientific Medicine" was discussed by Rev. C. B. Moulinier, S. J., Milwaukee, president of the Catholic Hospital Association, and "The Cancer Problem" was the topic of Dr. William Francis Campbell of Brooklyn, clinical professor of surgery of the Long Island College Hospital. The clinical congress of the American College of Surgeons for the New Jersey, Pennsylvania and Delaware sections was held Monday afternoon. Dr. Hedges presided at this session.

British Association for the Advancement of Science.—The ninety-second annual meeting of the British Association for the Advancement of Science will meet August 6-13 in Toronto, Canada. This association, founded in 1831, meets annually for a week or longer at important centers of the British empire other than London, England. Three previous meetings have been held in Canada in 1884, 1897 and 1909; the meeting in 1905 was in South Africa, that in 1914 in Australia. The average attendance at these meetings for the eighty-three years previous to 1920 was 2,330. There is no technical qualification required of applicants for admission as members of the association and no limitation in respect to nationality. A preliminary program will be forwarded on application to the local secretary, British Association, Physics Building, University, Toronto.

The report of the Morris County Medical Society meeting on May 27th was not received until this part of the Journal was ready for the press. It will appear in the July Journal.—Editor.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

CHAS. D. BENNETT, M. D., Chm., 750 Broad Street, Newark.

EDITOR:

DAVID C. ENGLISH, M.D.,
P. O. Box 83, New Brunswick

ASSOCIATE EDITORS:

CHRISTOPHER C. BELING, M.D., Newark
HENRY B. COSTILL, M.D., Trenton
JAMES HUNTER, JR., M.D., Westville
HARRISON S. MARTLAND, M.D., Newark
FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

We regret that, in justice to our advertisers, we could not issue this Journal before the Annual Meeting of our Society began. It will reach our members after that meeting has adjourned. It will doubtless be one of the largest and best meetings we have ever held. Next month we will insert the President's address and some Original Articles. The Orations will appear in the September Journal with the Official Transactions.

UNWORTHY PRACTITIONERS.

Dr. O. S. Wightman, president of the New York State Medical Society, in a letter to the New York Times, acknowledges that there are unworthy men in the ranks of the organized medical profession and claims that the society should see that these men cease to jeopardize the health of the community. He feels that the prosecution of the unregistered practitioners representing the cults is no concern of the medical profession and that the State through its police organizations

should deal with this class of lawbreakers. These contentions are logical but however bitterly we may feel because of the indifference of the State, as represented by the police departments, it may be in order to ask ourselves whether the glass house and the stone throwing may not in a degree apply to the medical profession. The President of the New York Society confesses to the fact that the profession in that State has not cleared its own skirts and he probably knows the facts. The same condition exists in all states probably. We have had a few members of our State Society who were convicted criminals, and we now have a very few who are believed to be engaged in criminal or dishonest practice. The Society has been indifferent in some instances, although we have the machinery which if put into action would bring results. We believe it should be put into action for the good of the profession and the public.

MEDICAL DEFENSE AND INDEMNITY INSURANCE.

At a recent meeting of the committee in charge of this matter, it was resolved that active steps should be taken to increase the number of members insured under the group insurance plan adopted by the State Society and contracted for with the United States Fidelity and Guarantee Company of Baltimore, Maryland.

This form of malpractice protection has been so successful and beneficial to the State Society that it has resulted in the reduction of the annual premium of \$32.00 for an individual limit of \$5,000, to \$16.00 a year. An increase in the number insured will probably result in a further reduction in the premium as the Company's agreement and contract stipulated. There is no question in the minds of the committee of the advantages to be gained by this form of protection. The Counsel for the Society assures us that there is no question as to the legality in form of the policy under which our members are now insured. The committee believes that all members of the Society should avail themselves of this privilege.

Up to the present time about 600 members have taken out policies in our company. It must be remembered that some competing companies propagandize the members of the Society as to the evils and dangers of group insurance. Group insur-

ance has been successfully operated in New York and other states as well as in this state. In co-operation there is strength! At the next annual meeting the committee will make a comprehensive report upon the results of this form of medical defense, setting forth the opinions of the counsel and the benefits that have already accrued from the operation of the present plan of Indemnity Insurance as adopted by the Society two years ago.

Christopher C. Beling.

PLAN FOR THE ERECTION OF AMERICAN HOSPITAL.

As a lasting memorial to the generous sympathy of the American people to Japan at the time of the earthquake, a portion of the surplus contributed through the American Red Cross to Japan relief is to be used in the erection of a large modern hospital in Tokyo to known as the American Hospital, for which another portion of the surplus will be set aside as an endowment fund. The suggestion of the Japanese Emergency Relief Bureau, which has been adopted by the American Red Cross, was that the \$4,500,000 surplus held for Japanese relief at the Red Cross should be divided into three parts. The first \$1,500,000 is to be used for immediate relief work among the yet many thousands of Tokyo destitute people. The second \$1,500,000 will be used for the erection and equipping of the proposed hospital, and the third \$1,500,000 will be set aside as an endowment fund for an institution of healing, which will carry in its name the thanks of Japan for America.

MENTAL DISORDERS ARE CIVILIZATION'S GREATEST FOE.

"Unless the medical profession becomes aroused immediately to an appreciation of the danger arising from their indifference to the problems of prevention and treatment of mental disorders, and to the still wider problems involved in assisting the average person to make good use of his mind, the chances not only of losing the effects of the discoveries made in the prevention and treatment of physical disease but of actually jeopardizing our entire civilization will be greatly increased." So writes Dr. Stewart Paton in Harper's. Dr. Paton is lecturer on neuro-biology at Princeton University. "The campaign to find out more about our minds, and to apply the knowledge we already have," he continues, "is the

only rational basis from which the fight against physical disease can be conducted successfully. Good physical hygiene depends upon good mental hygiene. The control of syphilis, tuberculosis, typhoid, typhus and plague involve primarily the cultivation of good mental habits.

"The fight against physical disease would doubtless have been far more effective had the members of the medical profession devoted more time and attention to the cultivation of the art of forming good mental habits and observing the precautions essential for clear thinking."

MEDICAL LEGISLATION.

Do you know how your candidates for the legislature feel on the subject of medical legislation? Get acquainted with them and find out what they know about the medical situation. Make it clear to them that the State has a right to fix the qualifications for the practice of the healing art and that we as regular practitioners of medicine do not care about the kind of treatment used and actually would oppose dictating any peculiar form of treatment, but we are interested in knowing that those who hold themselves out to treat disease shall have a knowledge of the human body as obtained by such preliminary education as we now demand of our students who graduate from the medical department of Indiana University or any other recognized medical college.—*Indiana Medical Journal*.

YOUNG DOCTORS WANTED.

Young doctors who have had at least one year's post-graduate experience are being solicited by the Surgeon General of the Army to adopt the service as a career, according to a War Department announcement made public today. The official circular authorizing examinations to be held during the week commencing Monday, July 28, gives the following regarding eligibility:

The applicant must be a male citizen of the United States, a graduate of an acceptable medical school legally authorized to confer the degree of Doctor of Medicine, must have had at least one year's hospital training subsequent to the completion of a four-year course of instruction in such medical school, or, in lieu thereof, have served one year as a medical officer of the United States Army between April 6, 1917, and July 1, 1919, and must be between the ages of 22 6/12 and 31 6/12 years at time of examination.

The necessary blank forms may be obtained from the Adjutant General of the Army, Washington, D. C. Applications from those residing in the States of New York, New Jersey, and Delaware should be mailed to Commanding Officer, Second Area, Governors Island, N. Y.

LAWYERS WOULD BAR ALIENISTS

The unreliability of expert testimony was the subject of discussion before the recent meeting of the New Jersey State Bar Association with the result that a committee was appointed to confer with a like committee representing the State Medical Society on measures calculated to eliminate unreliable expert testimony, especially with respect to a person's mental condition.—*The Nation's Health*.

PROMISED CURE FOR CANCER.

The following editorial appeared in the May Boston Med. and Surg. Journal which we commend as worthy our readers' consideration.—Editor.

The daily papers have announced that Dr. Fichera of Padua claims to have developed a prevention of cancer and promises a probable cure of the disease by the use of sera.

American Medicine for March, 1924, published an article by William Held, M. D., of Chicago, in which the claim is made that a similar method of treatment is of value. While the world is expecting a solution of the etiology of cancer and methods for its prevention and cure, past experience leads to conservative skepticism regarding claims of this nature.

Very few revolutionary theories which have appeared in the daily press have been found to stand the test of scientific investigation. It is true that one great discovery in recent times was heralded in the newspapers before scientific reports were published but even with the few examples of valuable announcements there have been many false hopes held out that doubt of the importance of sensational claims is reasonable. We hope that we are on the verge of great discoveries but we still feel that publication of reports of prevention or cure should be postponed until authorities other than the claimant shall have verified the findings. It is not only cruel to raise false hopes but unproved claims may lead to so many importunate requests from sufferers that even scientific investigation may be hampered. We cannot blame the newspapers for the publication of impressive news items. It is the ambition of editors and reporters to be first in the field when important and even vital information is acquired but the ambition for publicity should be tempered with regard for scientific accuracy.

Since the claims for discovery of means

for the control of cancer have been published we must wait patiently for the truth and not express opinion in advance of actual demonstration.

SERVICE AND SELF.

The modern luncheon clubs of business men are signs encouraging that the world is growing better. They are also proof that it matters not how any club may come to be organized if it would perpetuate itself and commend itself to good men and society in general it must sooner or later become helpful and unselfish. The Rotary Club has as its motto, "He profits most who serves best." The Kiwanis Club has a shorter phrase, "We Build." Both clubs ask for public commendation because of their unselfish ideals and program.

The Rotary Club has a shortened form of its motto, "Service—not self." When understood, as they understand it, it deserves praise. But when practiced as many practice it the mark is missed. To give self and not service is inconsistent. The latter is not often seen. What society needs is for business men to give themselves with their service.—*Presbyterian Magazine*.

We are glad to insert the above from a religious paper and note that these clubs have the true spirit of the medical profession. Surely Service and Self characterize it preeminently. A New Jersey judge, now a State Senator said: "From my study and observation of the medical profession I am decidedly of the opinion that it is the most unselfish body of men in the world." Let us as members of it seek to keep it worthy of such commendation as we give Service and Self.

CHARACTER BUILDING.

The future strength of a nation lies in its children, and this strength is largely dependent upon the physical and moral training of these same children. The boys and girls of today are the men and women of tomorrow, and in their hands is the future of the nation.

Boys can be made our most valuable asset or our greatest liability. They are the very cornerstone of society. The future manhood of every boy and his place in the world will depend in a large measure on what we make him.

An honest, upright, decent, clean boy is

not easily led into wrong-doing. Bad men come from bad beginnings in boyhood, and bad beginnings come from bad company. Most confirmed criminals become such before they reach the age of twenty-one.

Boys respond quickly and willingly to good influences, but what most of them require to keep them from evil is an opportunity to be busy at some interesting occupation.—*Chicago Department of Health.*

MEDICAL SOCIETY OF NEW JERSEY.

New Members.

Allaben, Anna L., South st., Morristown.
Arbuckle, Harvey, Boonton.
Beaver, Jennie Dean, High st., Morristown.
McCormack, William G., Whippany.
Peeler, Cooper S., Gloucester City.
Reed, R. Ralston, Morristown.
Shope, E. P., Mendham.

Miscellaneous Items

No Need of Doctors' Speeding.

To the Editor of the Tribune.

Sir: Recently several letters have appeared in your columns relative to "speeding doctors." As all those I have seen thus far are by laymen, I think it would not be amiss if an M. D. expressed his views.

For a long time there seems to have been a common notion among people not doctors that a certain amount of boorishness, professional bad manners, and often downright insolence is a necessary part of the medical man's equipment. Consequently, many physicians, particularly the younger ones, affect a manner of arrogance and studied discourtesy often mistaken for dignity and as marks of great ability.

There isn't a single plausible excuse for giving any private practitioner of medicine the same right of way as ambulances, fire apparatus and patrol wagons. There never was a time in the life of any private practitioner when he could not make all the time necessary and at the same time conform to traffic regulations.

In a municipality such as New York, and even in the surrounding towns, where ambulance service and police are available, there is no good reason why doctors should be given any privilege not given to every other person, and I, for one would insist that they obey to the letter not only traffic but all other laws.

ROBERT P. WHITE, M.D.

Jersey City, N. J., Feb. 24, 1924.

The Tragedy of Quackery and Procrastination in Cancer.

The fear of the knife and the prevailing opinion that cancer is a hopeless condition are probably the two main reasons that quackery has profited so greatly in exploiting sufferers from cancer. Furthermore, while excellent results may be obtained in early cases of cancer, at the present time, many cancer patients learn of their disease only when their condition is far advanced and the

chances for recovery poor. Scientific medicine must, in honesty, admit this, and must also admit that it does not possess a specific remedy against cancer. The quack, however, is either certain, or claims to be certain, that his remedy is sure cure for every cancer case. The patient takes a chance with the one who promises him most, and thus misses the opportunity to obtain the correct treatment in the early stages of the disease. All this is characteristic of human nature and applies as much to bucket shops as to cancer cures. The dupes in both cases are the ignorant and inexperienced; and the remedy in both cases is education. A secret remedy cures only the empty pocket of the quack.—Bulletin N. Y. Department of Health.

Mrs. Jessica Henderson Versus President Coolidge.

According to newspaper reports Mrs. Henderson has sent a communication to President Coolidge, in which she refers to "vaccination tragedies and failures" and protests the unlimited police power of boards of health. She asks the President to put a stop to the activities of these boards. She warns the President that if he fails to pay attention to the subject of vaccination, with the implied suggestion that he should ally himself with the League, the proponents of the American Medical Liberty League will make a campaign issue on vaccination and carry it to the polls. We have always felt sorry for Mrs. Henderson who, aside from her mistaken beliefs, is a worthy and kindly person. She is energetic, magnetic and consecrated to her beliefs. This threat is suggestive of a mind unbalanced by over-enthusiastic activity in advocacy of an erroneous conviction.

Real men are not won over to a particular cause by a political threat.—Boston Med. and Surg. Jour.

Three Chiropractors Serving Jail Sentences.

—Lynne W. Frye, formerly a chiropractor at Mt. Holly, now at Riverside, says he will serve thirty days in the Burlington County jail rather than pay a fine of \$500 on a charge of practicing without a license. This is the second conviction, a fine being paid in the first instance. Two other chiropractors in New Jersey are serving jail sentences for practicing without a license. They refused to pay fines. They are Meade H. Whiteside of Trenton and John H. Conover of Union Hill.

What Next?—The Jamestown, N. Y., Journal gives details of a hearing before the City Board of Public Welfare, at which several chiropractors demanded the right to send patients to the City Hospital and to treat any there desiring chiropractic treatment. For two hours the back breakers argued with the Board and health officials when it was finally decided that the Board should obtain legal advice on the matter. According to Attorney George W. Whiteside, counsel of the State Medical Society, there was no question but that chiropractors who practiced what they are pleased and accustomed to call their profession (?) are doing so in violation of the laws of the State. Chiropractic, he says, is scientifically unsound and should be fought as a plague, and its practice a crime which no political expediency

can condone. The lack of sense of fitness of this is easy to understand, but not how they could hold the attention of the Board for two hours.

Surgeon Sued for Performing Operation Without Patient's Consent.

At Capetown, South Africa, a case came before the supreme court in which a surgeon was sued for \$50,000 damages because he performed a serious operation for cancer in a public hospital, without the patient's consent. He was, however, under the impression that the patient's consent had been obtained, and he maintained that the operation was the only method of preventing death. The plaintiff's lawyer argued that his client was entitled to refuse an operation and take the risk of death, and that the surgeon should have explained to him the necessity for operation and obtained his consent. The jury returned a verdict for the defendant.—Federation Bulletin.

Veteran-Chiropractor Decision.

In upholding the veteran chiropractor law, the Supreme Court has in the case of this particular method of medical treatment opened wide the doors to practitioners without putting them to the test of capacity and reliability that is required of other branches of the healing arts. The case should be carried higher, and, if sustained by the Court of Errors and Appeals, the repeal of this law which disappeared in Senate committee should be passed at the next session.

The decision just rendered in a case pending for months upholds the validity of Chapter 161 of the laws of 1923. Chapter 161 provided that the Medical Board of the state must license as a chiropractor, without examination as to knowledge of the healing art or evidence as to moral character, any World War veteran who has been graduated by any incorporated chiropractic college under jurisdiction of the Federal Board of Vocational Training.

The Medical Board refused a license to an applicant under its provisions whose case was employed to test the question before the courts, in behalf of some two-score other intending applicants. The Medical Board, responding to an order to show cause why it should not be compelled to issue the license, contended that the law was special and therefore unconstitutional legislation, and was, moreover, opposed to public policy.

The court holds simply that "the undoubted intention of the Legislature" was to require the board to do what it objects to doing as against the public interest; that the legislative intent was that no qualifications should be required save those provided for in the specific act, and that, since this is "the only construction that can be placed upon this statute," the veteran in question is entitled to an order to the Medical Board to license him.

Within a year the country has seen the gravest scandal of its history in the field of healing. That a school of healing of any cult is incorporated is not the slightest guaranty of its ability to teach anything. The fact that a man has been trained in an incorporated school is, therefore, no test of his fitness to take the lives and health of people in his hands.

We have found grave faults, moreover, in

federal administrative bureaus charged with the welfare of veterans. That cultivates no confidence that the federal rehabilitation service is an assured steward of training in the healing art, to say the least. And a man may have been a fine soldier, a devoted patriot, a faithful student—yet none nor all of these would assure that high moral character which the general law requires of the doctor, whose relationship to the family is even closer than that of the priest, in most cases.

New Conquests of Disease Indorsed by an Authority.

Reports of a new serum treatment for scarlet fever have been sparingly commented upon by laymen, for the reason that the discoverers themselves and medical commentators have heretofore warned against rash conclusions in the presence of uncertain data. Dr. William C. Park of New York, however, is an authority whose word goes far in such matters, and his indorsement of the claims for the treatment on the basis of experience with its use in Willard Parker Hospital, New York City's great institution for the isolation of infectious diseases, will be widely accepted as conclusive.

After referring to the reported discovery last fall, by Dr. and Mrs. Dick, of a serum treatment based upon the apparent identification of a form of streptococcus as the cause of the disease, Dr. Park told a gathering of public health and charity workers recently: "We have used this in Willard Parker Hospital with very considerable success." He described it, not as a definite cure for the developed disease, but as a means of determining susceptibility and imparting immunity, like the Schick test for diphtheria and the supplementary toxin-antitoxin for immunizing susceptibles to that one-time decimator of child life. Ultimately, of course, that means practical eradication, as in smallpox.

Dr. Park, moreover, indicated that measles, which is a far more serious thing than uninstructed parents realize in its potential direct and indirect effects, is on the threshold of control. As to this he is quoted as saying:

"In measles we do not yet know the nature of the organism producing it, but we do know that in the serum of those who have had the disease there is a marked accumulation of protective substances. If some of this serum is injected into a child who has been exposed for not more than five days, the disease is either prevented or made so mild that it is but a trifling complaint."

If the danger is realized in time, therefore, he added, "in three of the most feared diseases of childhood we now have remedies which enable us to prevent the development of the infection * * * and in diphtheria and scarlet fever we have vaccines which make it possible for us to eliminate them." He might have added further that we have a method which greatly minimizes the dangers of whooping cough, a fourth disease that takes more child lives than those unfamiliar with medical statistics comprehend.

As the wonders of serum therapy multiply, it becomes increasingly a marvel that there still are individuals who keep alive movements to combat vaccinations and the animal

experimentations through which alone it is extended in benefits.

Report of the Committee on the Standardization of the Degree of Disability in Industrial Eye Injuries.

By ELBERT S. SHERMAN, M. D., Chm.

This report is concerned solely with the determination of the percentage of visual disability caused by industrial eye injuries in this State. Legal enactments and judicial interpretations place definite limitations on the scope of such a report. For instance, we are not permitted to consider the age of the injured employee or the nature of his occupation; his technical ability or his ability to compete. To some extent and by implication, the law takes these conditions into consideration by basing the amount of the award on earning ability (daily wages).

The Employers' Liability Act in this State makes no attempt to define normal (standard) vision or industrial blindness, or direct how the percentage of visual disability shall be determined. All this is left to the eye surgeon.

The following extracts from the law are about all that we have to guide us:

Sec. 2, Art. II., Par. s.—"For the loss of an eye, sixty-six and two-thirds percentum of daily wages during one hundred weeks." (Minimum eight, maximum seventeen dollars a week.)

Par. v.—"The loss of.....both eyes..... as a result of any one accident shall constitute total and permanent disability." (Compensation is awarded for four hundred weeks.)

Par. w.—"In all lesser or other cases involving permanent loss, or where the usefulness of a member or any physical function is permanently impaired, the compensation shall be sixty-six and two-thirds percentum of daily wages, and the duration of compensation shall bear such relation to the specific periods of time stated in the above schedule as the disabilities bear to those produced by the injuries named in the schedule; **provided, however**, that in cases in which the disability is determined as a percentage of total and permanent disability, the duration of the compensation shall be a corresponding portion of five hundred weeks."

In addition to keeping within the legal limitations we have, with some minor exceptions and elaborations, followed established custom and procedure in this State and have adopted, as far as possible within the above limitations, the teachings of recognized authorities on visual economics. Our chief aim has been to offer a method that would be simple and practicable and at the same time fair to both employee and employer. This, as well as all other methods that have been proposed for estimating the percentage of disability caused by eye injuries, are more or less arbitrary. Common sense and good judgment should be used in their application to individual cases. This report is offered only as a general guide. Unusual and exceptional cases will require special consideration.

In the interest of uniformity we would prefer to have waited for the adoption of a report by a similar committee of the American Medical Association, but the reports thus far presented by the committee have not been

adopted, and have received considerable adverse criticism. In fact the last report has apparently been jettisoned and the committee is working on a new report.

We accept and endorse the teaching of well known writers^{1, 2} on visual economics that in the function of vision there are three essential elements, (a) visual acuity, (b) binocular single vision (muscle function), and (c) field of vision, and that each element stands in the same relation to the others as do the factors of a product. After the measurement of these essential elements by the usual and accepted methods, we recommend the following principles* for the determination of the numerical, co-ordinate value of each element:

Visual Acuity.—The total value for full normal visual acuity shall be an integral factor. Its total or partial numerical value shall be determined by using test-types, constructed in conformity with the accepted Snellen standard.

Muscle Function.—The co-ordinate numerical value of muscle function shall be determined on the principle that the loss of binocular single vision is equivalent to the loss of the use of one eye. The numerical value of this factor is 0 when there is an irremediable diplopia, and when there is partial diplopia it is a fraction proportionate to the area of the motor field in which there is persistent diplopia.

Field of Vision.—A square root value shall be given to this factor. The primary numerical value for any part of the field shall be proportionate to its concentric contraction, and the co-ordinate numerical value for this factor shall be the square root of that quantity which measures the concentric area of the remaining field determined by the perimetric measurement.

For determining the numerical values of the elements, visual acuity and field of vision, we submit the following tables:

Table 1. Visual Acuity.

Showing percentage of visual impairment as shown by the ability to read standard test type.

Snellen expression	Percentage value of visual acuity	Percentage of loss
20/20	100.	0
20/30	94.5	5.5
20/40	89.	11.
20/50	83.5	16.5
20/60	78.	22.
20/70	72.	28.
20/80	67.	33.
20/100	55.6	44.4
20/120	44.	56.
20/150	28.	72.
20/180	11.	89.
20/200	0.	100.

(industrial blindness.)

This table is based on the assumption that 20/20 is normal vision, and 20/200 or less is industrial blindness. These standards have been used and accepted in this State for several years.³ About 95 per cent. of permanent disability cases can be settled by this

*From the Report of the Committee of the Medical Society of the State of New York on the Compensation of Ocular Disability Resulting from Industrial Injury or Disease.

table alone. Impairment of visual field from injury, without coincident serious impairment of visual acuity, is rare. Traumatic paralysis of the ocular muscles is also infrequent.

Recognizing that impairment of the visual field is much less important than proportionate loss of visual acuity and that its importance is accentuated as the contraction increases, we agree with Magnus and Wurde-mann⁴ and A. C. Snell⁵ that this element should be given a square root value when used as a factor in estimating total visual function. This treatment allots relatively small value to slight impairments of the field and disproportionately increasing value as im-pairment increases. The following table is by Dr. Snell:

Table 2. Field Vision.

Contraction		Percent of		Co-ordinate
65° to		Normal		Value of
65°	==	100.	square root of	1.00
60°	==	92.	" " "	.96
55°	==	83.	" " "	.91
50°	==	75.	" " "	.86
45°	==	67.	" " "	.81
40°	==	59.	" " "	.76
35°	==	50.	" " "	.71
30°	==	42.	" " "	.65
25°	==	33.	" " "	.58
20°	==	25.	" " "	.50
15°	==	16.	" " "	.40
10°	==	8.	" " "	.28
5°	==	0.	" " "	0

No table can be constructed that satis-factorily expresses the percentage of disability caused by paralysis of one or more external ocular muscles. If the condition is incurable, causing persistent diplopia, it necessitates the constant closing or covering of the affected eye, thus rendering the individual practically mon-ocular. Such cases should be awarded compensation for total loss of the eye.⁶ Other cases, as of partial paralysis in which there may be diplopia in only part of the field of fixation, should be given a smaller award proportionate to the diplopia area.

For permanent, complete paralysis of ac-commodation of one eye, with which is usually associated mydriasis, we believe a loss of 25 per cent. should be awarded.

Method for Computing Percentage of Ocular Disability.—After determining the primary numerical value of each of these elements—visual acuity, field of vision and muscle function—the total visual ability is obtained by treating these values as factors and multi-plying them together. This may be expressed as an equation in which V represents visual acuity, F field, M muscle function and A total visual ability, thus: $V \times \sqrt{F \times M} = A$.

In a case of normal or 100 per cent. vision, the value of each factor would necessarily be one. Substituting this value the formula would be: $1 \times \sqrt{1 \times 1} = 1$ (or 100%).

Total loss of any of these elements gives a 0 value to the corresponding factor and, of course, a 0 product, as follows:

- For visual acuity — $A = 0 \times \sqrt{1 \times 1} = 0$
- For field — $A = 1 \times \sqrt{0 \times 1} = 0$
- For muscle function — $A = 1 \times \sqrt{1 \times 0} = 0$

To obtain the percentage of impairment when there has been partial loss of one of the elements of visual ability, the percentage value of remaining function is substituted as a factor in the equation.

When only one of the elements is damaged, the percentage value of remaining visual abil-ity is the same as the value of the element impaired.

Illustrative Cases.—Case 1. Macula of cornea, partially covering pupillary area, caused by a lime burn six months previously. Vision 20/50. No other damage to eye. Re-ferring to Table 1, it is found that 20/50 is equivalent to 83.5 visual acuity, giving a loss of 16.5.

Case 2. The right eye of a machinist was perforated by a small fragment of metal which entered through the anterior part of the sclera, avoiding the lens, and passed through the posterior part of the eye, above the macular region, into the orbit. Six months later the vision was 20/40 and there was a blind area in the lower part of the visual field, estimated to be equivalent to a con-centric contraction to 45 degrees. Referring to Table 1 and 2 we find that 20/40 represents a visual acuity value of .89 and contraction of field to 45 degrees leaves a co-ordinate field value of .81. Substituting these values in the preceeding formula we have: $.89 \times .81 \times 1 = .72$ visual ability, or .28 loss.

Case 3. A carpenter was struck in the right eye by a nail causing a small superficial wound of the cornea, which healed promptly. Two months later he claimed that the vision of the eye was very much impaired, and as-serted that it had been good previous to the recent injury.

Examination of the eye disclosed no scar on the cornea and there was no indication, in the fundus or elsewhere, of injury. The vision was considerably less than 20/200. The eye converged slightly, and the refractive error was—5.50 sph.—4.50 cyl., ax 45°. The vision of the left eye was 20/15.

The right eye was undoubtedly congenitally amblyopic, and the claim for compensation for permanent disability was not allowed.

Injury to Both Eyes by Same Accident.—Damage to both eyes, particularly when it is considerable in degree, is much more serious, proportionately, than when only one eye is damaged, and the percentage of disability is greater than the sum of the disability of each eye, computed separately. Our compensation law takes this into consideration in the latter part of paragraph w (which we have already quoted), which says: "Provided however, that in cases in which the disability is determined as a percentage of total and permanent dis-ability, the duration of the compensation shall be a corresponding portion of five hundred weeks."

Computation of the disability caused by in-jury to both eyes by the same accident is therefore on a total disability basis. On this basis the duration of the compensation is 2½ times as great for each eye, as it is when the computation is for one eye alone. Conse-quently the percentage of disability of each eye as determined by the method for mon-ocular injuries should be multiplied by 2½, and the sum of the two products is the du-ration of the compensation in weeks. Thus

if in a given case the vision of one eye is 20/40 or 11% loss, and the other 20/70, 28% loss, the computation would be $11 \times 2 \frac{1}{2} + 28 \times 2 \frac{1}{2} = 27 \frac{1}{2} + 70$ or 97 $\frac{1}{2}$ weeks.

Traumatic Cataract and Glasses.—In accordance with a Supreme Court ruling,⁷ measurements of visual acuity in compensation cases in this State must be made without the aid of glasses. This apparently, would not apply to any visual impairment that existed before, but only to the increase caused by the injury. As a matter of fact, impairment of vision caused by injury is usually of such a nature that it cannot be improved by glasses. The most common exception is traumatic cataract. As the uncorrected vision of an eye with cataract, even after the most successful operation, is almost invariably less than 20/200, such cases, by this judicial decision, must be compensated on the basis of 100% of visual disability, although 20/20 vision (with glasses) may be obtained after removal of the cataract.

Secondary Considerations and Suggestions.—No estimate of the amount of permanent disability should be made until function has been as fully restored as possible by approved medical and surgical treatment. After the complete subsidence of acute symptoms, sufficient time should elapse for the further and gradual improvement of vision that often occurs and continues over a period of months, or for the development of sequelae, before a final examination is made. This applies particularly to cases of corneal injury, iridocyclitis, sympathetic ophthalmia, optic nerve atrophy and paralysis of the ocular muscles. Usually the impairment of vision caused by central and para-central scars of the cornea gradually improves for many months after the injury, and in some cases the improvement found after the lapse of a year is astonishing. A recently observed instance was a young man who had an injury near the center of the cornea, leaving a superficial scar 3 mm. in diameter. Five months after the injury the vision was 20/60. Nine months later the scar was almost invisible and the vision was 20/20.

In cases of injury in which the vision has been previously impaired, compensation should be awarded for only such portion of the disability as may reasonably be attributed to the injury on account of which the computation is being made. Slight cosmetic defects and disfigurement are not compensable unless they cause functional disability. Certain types of defects which cause disturbance of function such as ectropion, entropion, injury of the lacrimal drainage system, traumatic coloboma of the iris with persistent dazzling and photophobia, should receive special consideration and additional compensation.

Reports on visual impairment to employers, lawyers, insurance carriers and courts should be made in terms of percentage of disability, and not in Snellen fractions.

It often happens that an eye which is already more or less defective is injured, causing still further impairment of vision. In such a case, without some record of the vision before the injury, it may be impossible to separate the impairment caused by the injury from that pre-existing, and the examiner can only use his best judgment.

We therefore recommend that employers

engaged in manufacturing have a simple visual test made of all new employees, and a record kept of the vision.

REFERENCES.

1. Magnus and Wurdemann: Visual Economics, p. 30.
2. A. C. Snell: Archives of Ophthalmology, Jan., 1924.
3. E. S. Sherman: Journal of the Med. Soc. of N. J., Nov., 1923.
4. Magnus and Wurdemann: Idem. p. 32.
5. Snell: Loc. cit.
6. Magnus and Wurdemann: Idem. p. 65.
7. Johannsen vs. Union Iron Works..

Elbert S. Sherman, M.D., Chairman, Newark, N. J.
Chas. H. Schlichter, M.D., Elizabeth; Alfred Cramer, Jr., M.D., Camden; Elias J. Marsh, M.D., Paterson; Wm. Goodwin, M.D., Newark; W. D. Olmstead, M.D., Trenton.

Hospitals; Sanatorium, Etc.

A donation of \$1,000 will be donated to the Beth Israel Hospital fund by Composite Lodge, No. 223, F. and A. M.

All Souls Hospital School for Nurses, Morristown.—Four women were graduated from the school May 20th.

Burlington County Hospital, Mt. Holly.—Mr. J. J. White of New Libson, bequeathed \$5,000 to the hospital.

Dover General Hospital.—The new hospital will be on the Phillips Farm in West Blackwell Street, near the Pine Terrace Inn. The money for it was raised in the campaign recently when about \$153,000 was collected. The new hospital will serve Dover and adjoining towns in Northern Morris and Southeastern Sussex County.

Elizabeth General Hospital.—Ten nurses were graduated on May 12th from the Training School of this hospital.

Homeopathic Hospital of Essex County.—The new hospital building which is to cost \$500,000, will take the place of the present building on Littleton Avenue which has not only outgrown but is incapable of expansion because of restricted grounds. The new building at Central and South Munn Avenues, East Orange, is to be six stories high of steel, concrete and brick. Although known as the Homeopathic Hospital, it will be a general institution, open to any physician or surgeon, for all classes of patients.

Memorial Hospital, Morristown, School for Nurses.—Eight students were graduated from this school on Friday evening, May 23rd.

Mountainside Hospital, Montclair, Staff.

Walter B. Mount, M.D., Reporter.

The regular monthly meeting of the clinical staff conference was entirely taken up by an interesting and instructive talk by Dr. Joseph Colt Bloodgood of Johns Hopkins Medical School, Baltimore, who spoke particularly of diseases of the mouth and jaw. There were many outsiders at the meeting and the large classroom of the old Nurses' Home was crowded. Excellent slides were shown. A full report of Dr. Bloodgood's talk will be forwarded you later for publication.

Newark City Hospital.—The medical board of the City Hospital has re-elected Dr. H. J. F. Wallhauser and Dr. Francis R. Haussling president and vice-president, respectively, of the board. The following physicians were elected to the executive committee: Drs. Charles E. Teeter, Richard N. Connolly and Clarence R. O'Crowley. The ex-officio members of the board are Dr. Wells P. Eagleton, Dr. E. Zeh Hawkes and Dr. Earl H. Snavley, superintendent of the hospital.

Orthopaedic Hospital and Dispensary, Orange.—The report of Dr. R. E. Humphries, surgeon in chief, shows a thirty-eight per cent. increase in the number of patients admitted in the hospital. In the dispensary 1,511 new patients were treated during last year and 1,451 old patients returned for treatment, making 17,279 visits to the dispensary. Nurses and doctors attached to the dispensary made 1,738 visits to the homes of patients. The 2,962 patients who received treatment were given attention as follows: For some form of joint tuberculosis, 161; infantile paralysis, 418; spastic paralysis, 67; deformity of the feet, 350; rheumatic affections of the joints, 947; osteomyelitis, 53; for some form of bone fracture, 146.

Of the dispensary patients 478 were discharged entirely cured, 497 were relieved in their ailments and 434 came for consultation only, not requiring medical attention. Fifty-nine were referred to other clinics, fifteen died and 1,479 were continued on the registry lists taken of 1,102 patients. In the hospital division 245 patients were admitted for treatment, receiving 11,379 days of care. There was an average of thirty-two persons a day in the hospital. The average stay in the institution was 46.5 days, compared with 61.25 days in 1922. This decrease is attributed by Dr. Humphries to the fact that many patients can now be sent to the Westfield Country Home in cases of bone and joint diseases, where conditions lead to quicker natural reaction to treatment. During 1923, 391 operations were performed in the hospital. Of these four were fusion operations for tuberculosis of the spine, two for fracture and one for malformation of the spine. Ten fusion operations also were performed in cases of infantile paralysis and one for tuberculosis of the knee joint. The remainder of the operations were for the reduction of fractures or the correction of a variety of deformatory conditions.

Overlook Hospital, Summit, School for Nurses.—Seven young women were graduated from this school on Tuesday, May 20th.

St. Peter's Hospital, New Brunswick, School for Nurses.—This school graduated ten nurses on Thursday evening, May 22nd.

Bonnie Burn Sanatorium.—Dr. J. E. Runnels, superintendent, reports that on March 1st there were 250 patients in the sanatorium, 135 male and 113 females. This included 78 children in the preventorium. Since the last report 21 patients have been admitted, 10 males and 11 females. Nine of these admissions went to the preventorium. The admissions are classified as follows: Protubercular

9; moderately advanced, 4; incipient, 1; far advanced, 7. Present on April 24th, 259. This number includes 80 children in the preventorium and 79 out of county patients.

All Souls' Hospital Nurses Rewarded.—Mrs. M. E. Wilson, Morristown, left her estate to the Sisters of Charity of that hospital, "in appreciation of their kind and faithful care of me," while she was a patient in the hospital.

State Village For Epileptics, Skillman.—The sixteenth annual exhibition of work of the patients in the New Jersey State Village for Epileptics took place Saturday, June 7, from 10 A. M. to 12 M., daylight saving time. An operetta, "Over the Rainbow," was given by the patients between 2.30 and 5 o'clock in Smally Hall.

Marriage.

COHEN-MYNEMAN.—At Jersey City, N. J., April 6th, 1924, Dr. Harry F. Cohen of Jersey City, to Miss Ethel W. Myneman of Oyster Bay, N. Y.

Deaths.

HAINES.—In Newark, N. J., April 23, 1924, Dr. Eleanor Haines, aged 78 years. She graduated from the Woman's Medical College in 1871; she was a member of the Essex County and State Medical Societies.

HUSTED.—At Woodstown, N. J., April 29, 1924, Dr. Joseph M. Husted, aged 49 years. He graduated from the Baltimore Medical College in 1897; was a member of the Salem County and State Medical Societies; member of the Board of Health and the County Memorial Hospital Staff.

MOONEY.—In Jersey City, May 20, 1924, Dr. John J. Mooney, aged 52 years. Further notice will be given next month.

POLLARD.—In Atlantic City, N. J., May 25, 1924, Dr. William M. Pollard, aged 69 years.

Dr. Pollard was born in Maine; graduated from the Jefferson Medical College in 1882; practiced medicine in Atlantic City for forty years; was formerly president of the Academy of Medicine and superintendent of the local schools; was a member of the Atlantic County and the State Medical Societies and a Fellow of the A. M. A. He was a pioneer in the scientific process of exterminating the mosquito; was a member of the County Extermination Commission.

SOULE.—In Newark, N. J., April 30, 1924, Dr. Robert E. Soule, aged 51 years. He graduated from the Long Island College Hospital in 1899; was a member of the Essex County, State Medical Society and the A. M. A.; assistant professor of orthopedic surgery at the N. Y. Post-Graduate Medical School; served in the M. C. U. S. Army during the World War.

Public Health Items.

Newark Health Report.—There were 513 deaths during March, or a death rate of 13.4 per 1,000 of population. The principal causes of deaths were: Tuberculosis, 35 cases; cancer, 34; apoplexy, 40; organic heart disease, 78; pneumonia, 59; Bright's disease, 49.

New Jersey Health Report.—During the month of February, 1924, there were 3,677 deaths reported. There were 455 deaths among children under one year of age, 193 deaths of children over one year and under five years of age, 1,481 deaths of persons aged 60 years and over. The death rate for the month is 12.70 as compared with 12.01 for the previous month. The principal causes of death were: Diphtheria, 44; tuberculosis, 229; cancer, 296 pneumonia, 279; Bright's disease, 319.

New Jersey March Mortality Report.—During March there were 3,934 deaths reported, or a death rate of 13.53, being an increase of 1.52 per cent. over the preceding month. There were 513 deaths of children under one year of age, 227 deaths of children over one year and under five years, and 1,500 deaths of persons aged sixty years and over. A slight increase is shown in most of the classified causes of death, the most notable increase occurring in deaths from pneumonia and tuberculosis.

League of Nations Health Committee.—The first session of the permanent health committee of the League of Nations met in Geneva, February 11-21. It will meet twice a year. Dr. Thomas Madsen, head of the Copenhagen Serum Institute, was elected chairman: Drs. Velghe, Belgium, Sir George Buchanan, England, and Surg. Gen. Hugh S. Cummings, United States, were elected vice-presidents. The members of the health committee who represent the United States are: Surg. Gen. H. S. Cummings, U. S. Public Health Service, Washington, D. C., and Dr. Alice Hamilton, Harvard University Medical School, Boston.

Disease Prevention in Bergen County.—Dr. J. R. Morrow, superintendent of the Bergen County Hospital, says: The passing of winter and the termination of the season in which communicable diseases are most prevalent, provides an opportune time to present facts on this subject. Attention has been directed to the unusually small number of diphtheria cases experienced in Bergen County and other localities, and the statistics compiled are positive evidence that efforts directed toward its prevention, has accomplished desired results.

The prevalence of diphtheria as reported by the Health Department of the city of Newark has been diminishing for the cases of diphtheria developed in Hackensack, that the Board of Education, through its Medical Department, introduced the Shick Test and the administration of toxin-antitoxin inoculations. During the school year 1920-1921, eighty-five cases of diphtheria were reported, over a period of seven months from September to March inclusive, the highest number of cases occurring in December and January. 21 and 23 cases, respectively. In September, 1922,

1,500 children were immunized, followed by a decided drop in the number of cases of diphtheria in the city. The total number of cases of diphtheria for the seven school months the year following were seventeen, the highest number in any one month being five cases. The Shick test has been used extensively, each year since, with the result that during the year 1923 to 1924, only 7 cases of diphtheria have been reported from the schools to the Health Department.

Hackensack, one of the pioneers in this programme, blazed the way for the other cities of the county. Englewood and Ridgewood and other municipalities followed with this procedure with correspondingly satisfactory results, as herewith set forth. In Englewood in 1922, twenty cases of diphtheria were reported and the use of the Shick test and toxin-antitoxin was instituted at the beginning of the school term. A very large number of children received immunization and during the year 1923, only seven cases were reported. Its use is being continued and from reports up to date, 1924 promises to show an even lower rate. Ridgewood Board of Health reports satisfactory results from their somewhat limited experience, and are confident that with the continuation of the program they will materially reduce their number of cases.

The good to be derived from these preventive measures are absolute facts that are well established without question of doubt. The immunity produced by such protection is positive and with the practice universally established, diphtheria will cease to be a menace. Boards of health, boards of education, physicians and nurses and interested individuals generally, assisted by the enormous influence of the public press, have been instrumental in securing immeasurable benefits and this should and undoubtedly will serve as an example and an incentive, whereby the program can be carried on in increasing intensity.

Personal Notes.

Dr. L. F. Donohoe, Bayonne, has been elected president of the Board of Education, Bayonne, also president of the Bayonne Rotary Club.

Dr. Julius Levy, Newark, expects to sail for Europe on June 21st. He will read a paper before the International Association of Child Hygiene in London in July. He expects to return home in August.

Dr. M. J. Fine, Newark, has bought the home of A. C. Heusley, 175 Clinton Avenue, and will occupy it as his home and office after July 1st.

Dr. John C. Loper, Bridgeton, was recently elected medical inspector of the local schools.

Dr. Robert L. McKiernan, New Brunswick, has opened an office at 115 Jefferson Avenue, Elizabeth, where he will see patients by appointment. He will continue his office in New Brunswick also.

Dr. Henry B. Whitehorne, Verona, and wife recently took a trip to Virginia.

Journal of The Medical Society of New Jersey

Published on

the First Day of Every Month



Under the Direction

of the Committee on Publication

Vol. XXI, No. 7

ORANGE, N. J., JULY, 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

PREVENTIVE MEASURES IN DIPHTHERIA, SCARLET FEVER AND MEASLES.*

By William H. Park, M.D.,

New York City.

President of the American Public Health Association.

One word about the method of introducing diphtheria antitoxin. Of course we all realize diphtheria antitoxin acts by combining with the toxin and neutralizing it. It has no further effect. In the treatment of cases we wish to get sufficient antitoxin to the diseased area of the tissues throughout the body in a late case as quickly as possible and we have three methods. Two methods in common use and one not in use. The intramuscular and the intravenous and then the third which we have used a little in the hospital, the intraperitoneal. Now, if it were not for the effect of an intravenous injection which is somewhat difficult to make, especially in a child and apt to make chills, sometimes in children but more in adults, we would all give antitoxin intravenously because you save two days of absorption. If you inject as you know intramuscularly about half is absorbed at the end of the first day and about three-quarters at the end of the second and one-quarter another day. If you can give it intravenously the antitoxin is immediately in the circulation passing through the tissues. But we do hesitate to give it intravenously because a child, as far as I know, is very seldom in danger and so the tendency is to give it intramuscularly.

Now we happened to have with us a year ago Dr. Platou who used a great deal of intraperitoneal injections of food substance

and of salt solution. And so we thought we might try giving antitoxin and then bleeding the children and testing its rapidity of absorption and we found the intraperitoneal method was very much quicker than the intramuscular. In a little child that you cannot give intravenously and yet you felt you want more rapid absorption than from the muscles, the intraperitoneal injection is half way between the two, six times as rapid as the intramuscular method.

A few words on toxin-antitoxin. As you know, we have changed our preparation. When we began ten years ago we used a preparation which we had used for experimental purposes. In using that preparation we had a great deal of toxin, roughly speaking 140 fatal doses for a guinea pig and we used the equivalent amount of antitoxin so as to make it nearly non-toxic; but it caused pretty sore arms and marked local reactions. Two or three per cent. of the children and more adults showed a temperature and maybe the necessity to remain away from work for a day or two. And so we wondered whether it was necessary to have so much toxin and antitoxin. One-thirtieth the amount was finally used so that instead of having 140 fatal doses we only had one-thirtieth of that amount of fatal doses and we only had one-thirtieth that amount of antitoxin. We have been using it now for a couple of years and it has been accepted now as the universal mixture for this country.

One little objection has come up. That is, Dr. Hooper, one of the immunologists in Boston, tested a number of people who had received doses of toxin-antitoxin preparation and he found that a year later some of them, especially when they received an injection intracutaneously of horse serum, gave a reaction of sensitization. Even a minute amount of horse serum in sensitive individuals will cause sensitization in about

*Delivered at the Joint Meeting of the Rockland and Bergen County Medical Societies held in Pearl River, N. Y., May 7th, 1924.

20 per cent. There is a great deal of doubt whether it is of real practical importance. At the Willard Parker Hospital we injected children after intracutaneous tests without any regard to the reaction and we have not found any marked ill effects. In those cases you did not get a large reaction. Simply a reaction about the size of a 25c piece or possibly a 50c piece but it is somewhat of a talking point against the use of toxin-antitoxin. So it was suggested that we should produce antitoxin in goats and use the goat antitoxin for making the toxin-antitoxin so there would be no sensitization of human beings to horse serum.

However, it now looks as if we would not make this jump, but jump to a different preparation. You know in the very beginning that Behring and his co-workers immunized the first animals with diphtheria toxin which had been altered by the use of iodine or other substances which would break down the toxin into a killed, inert substance and it was found that this material would immunize animals just as well as the toxin and much more safely. Now about a year and a half ago in cutting down the toxin and the antitoxin it seemed to me that it would be an interesting point to know if we could not cut out the antitoxin altogether. I treated 200 people with a broken down toxin or "toxoid" and we found very little reaction. I had thought that as we would have a little more toxic substance (the proteins in the broth) that we would get more reaction. But apparently in breaking it down it changed the protein too. At least we did not get any marked local reaction so that in these cases 70 per cent. of these adults were immunized and only three out of 200 had reactions that amounted to anything. Just at that time I received a letter from Dr. O'Brien who is in charge of the Burroughs Wellcome Laboratory in London asking me whether we would use this "toxoid" that he had found in horses to be a very safe method and he had been trying out antitoxin with the "toxoid" and got a better preparation. His way of making the toxoid was to put 1/10 per cent. formalin with toxin. So with the knowledge of these 200 adults which had been treated locally with this preparation that I had made, I took this method and we have now tried it in a good many thousands of children with very good results. There has been very little local reaction and over 95 per cent. of the children have shown at the end of three months a negative Schick test which formerly were positive. We are at the present

time using the 1/10 L plus dose in half the children and "toxoid" in the other half. It looks as if we were gradually going to replace the toxin-antitoxin, but we will certainly make up a goat toxin-antitoxin to at least say we have done that; but I believe in a year we will gradually shift over to the "toxoid." One thing about the toxoid is that as far as we can see no possible harm could happen. About the trouble up in Concord, and other neighboring towns where a certain preparation made in the Massachusetts Board of Health, after freezing elaborated in each dose about two fatal doses diphtheria toxin. This was a preparation that had more toxin than the standard we are now making. This preparation is the only one that I know of that will become so poisonous. We have tried all of them and as far as I know the 1/10 will never do it. Combinations of toxin-antitoxin might in some way be separated as this case was in Boston. If we have a toxoid nothing of that kind could happen. The only thing that could happen is that it would become a little weak. A toxoid could have a much wider range as an immunizing agent. It hardly needs to be toxic at all. It has a wider range than toxin-antitoxin. We would come to the toxoid as the final way in the selection of an immunizing agent in diphtheria.

Recently I have been interested and we are now using in all the Brooklyn schools a substitute for the Schick test or a modification of the Schick test which may be of some practical interest. As you know a great many health officers and physicians hesitate to use a Schick test because they have not any practice and they fear that they would not give it correctly. Also they cannot afford in the schools waiting four days to read the Schick test, that meaning an extra visit. It struck me that possibly we could combine the Schick test with a subcutaneous test. So I tried with Dr. Schroeder to do a number of school children by first giving 1/10 L plus intracutaneously and then going deeper for the rest of the injection. When I came to read the children, I realized that with this larger amount given subcutaneously you will get an erythema, hyperemia of the skin, over that injection. So we began to test out several schools with a Schick test on the forearm and a subcutaneous test on the lower anterior part of the arm and the results came out uniformly. We found in the schools that by doing this we save a visit. Our way has been to do a Schick test or a Schick

test and a control and in four days giving the positive children the injection. In this way we go right into the school and do an arm test and then if the arm is positive we give two or three injections and if the arm is negative only one injection. I have here some photographs I made the other day. The point that I want to make you remember is that to use this test it must be strictly subcutaneous. I think subcutaneous is easier than the intracutaneous and the larger amount gives you some leeway but it should be definitely under the skin and we find that this anterior part of the arm is by far the best way to give it. If you give it any other place it is not so uniform.

Just a word on the results that we have had from toxin-antitoxin immunization. You probably remember that the first evidence we tried to get was, does the amount of antitoxin which means a negative Schick test really give immunity? In the work in New York Dr. Zingher and I first tested that out by making the test on our children in hospitals, and watching to see if any of those giving negative tests developed diphtheria. We always have about 6 per cent. in a year develop light diphtheria and we found that when we gave a second immunization that we had no loss of immunity. They remained immune so far as no case of diphtheria developed and with that evidence we thought that the theoretical evidence obtained by Schick was substantiated. Since that time we have been watching carefully and there are a certain number of cases of mild diphtheria or a sore throat with diphtheria bacilli happening in negative Schick cases. If you get a sore throat, suspicious of diphtheria, and you get no diphtheria bacillus it is not true diphtheria. If you get the same with diphtheria bacilli our tendency is to say that it is diphtheria. On the other hand we realize that 1 per cent. of the children in towns and cities are carriers of diphtheria bacilli. If that 1 per cent. of diphtheria carriers develop tonsillitis, of course they would show diphtheria cultures and simply finding a culture in a suspicious throat would not prove a case of diphtheria.

In New York City due to the general diphtheria propaganda and toxin-antitoxin immunization in the last five years diphtheria has dropped more than 5,000 in deaths and more than 40 per cent in cases. That is a pretty big drop. Five years ago we had 12,400 deaths, last year 576 deaths. The cases had dropped from 14,000 down to 8,500. We have a right to believe that the general effect of having every child in

New York City immunized that is going to school with a letter asking the parents to consult with the physicians and getting the consent of immunization so that every person in New York always knows a little more about diphtheria, a little more about antitoxin and these things all together have brought about a great deal of its reduction.

Scarlet Fever.—I want to have you realize that we are, in scarlet fever, where we were in diphtheria, say ten years ago. What I am going to say is what I think is true but not yet proven. Maybe next year we will have to take it back. Streptococci have been connected with scarlet fever for years and years. More than 35 years ago it was suggested that streptococcus was the etiological factor in scarlet fever. We know that every case of scarlet fever had abundant hemolytic streptococci. More abundant than other cases. It might be due to the fact that irritation of the throat by scarlet fever would allow the streptococci normally present to grow rapidly. We know that when you had an ear infection following or a mastoid infection, it is very dangerous to let those children or people go out because they almost surely give the infection to others and in that discharge there are hemolytic streptococci. In our laboratory in 1912 one of our workers took a swallow through a pipette of hemolytic streptococci and developed scarlet fever two days later. She had no contact with any scarlet fever. Just before the war, Dr. and Mrs. Dick working with a volunteer nurse sprayed the throat or swabbed it with streptococci from a case of scarlet fever and this volunteer developed scarlet fever. We have thought that the streptococcus not only was the most serious complicating organism in scarlet fever but we did not quite feel that septic sore throat was the same as ordinary scarlet fever and yet the streptococcus was certainly a very suspicious character in that regard. And then the Dicks, who have been working year after year on scarlet fever, thought that possibly if we tried human skin we could get something from the toxic products in the same way that Schick used the diphtheria toxin. We tried immunizing animals and found it would not do anything specific. The Dicks said maybe the human being, being the only one that will take scarlet fever, maybe the human skin is different. This was proven true and immediately the thing began to clear up. They got some volunteers and they injected a larger dose of toxin and they developed a typical moderate attack of so-called scarlet

fever from the toxin alone. Then in the Durand Hospital they tested out the nurses and those that gave the reaction they gave an immunizing injection of toxin sufficient to give them a mild scarlet fever-like disease for a day or two. Since that time none of the nurses developed scarlet fever. Before 6 per cent of nurses developed scarlet fever. The doctors did not wish to be immunized and one developed scarlet fever. They are all getting immunized at the Durand Hospital. It has come out that this toxin seems to be like the diphtheria toxin picking out the immune and non-immune.

Dr. Zingher in the Willard Parker with me has been testing every individual that came in and we absolutely substantiated and agreed with all the Dicks have done. The great majority of cases of scarlet fever that come in show a positive Dick test upon arrival and then later they show a negative test when they are bled. We have had several cases where the Dick test has been negative when they came in. Also we have found that the serum blanched also when it came in and that implies to us that those cases did not have the ordinary scarlet fever. We believe that this Dick test may help us in diagnosing special rashes. The Dicks found that they could give one big dose of toxin enough to give a scarlet fever rash and the patients would become immune afterwards so far as the toxin shows and so far as the Durand Hospital shows they were immune. We are trying to give three injections and we found that after two weeks the children failed to respond in the small number that we had just injected in that length of time. We believe we can immunize just the way we do with toxin-antitoxin. It may be possible to put the two together so that we can give the double dose of diphtheria toxin and scarlet fever toxin.

As you know, Dr. Dochez working entirely independently of the Dicks through a scheme he thought of injected horses with agar and into the agar he injected the streptococci from scarlet fever cases and the serum from these horses when injected into the skin of the scarlet fever case would blanch it. From that he thought that that serum was antitoxic. Dr. Black of the Johns Hopkins has used it and we have used it at Willard Parker. The results are rather striking. The fever drops and the rash disappears quite quickly, but it has shown that the fever would drop from 103½ or 104 over night to 99 and quicker than the average case has dropped. It looks as

though we have achieved the same thing as we have with diphtheria antitoxin. Also you can refine the serum in the same way as we can make the antitoxin by giving the scarlet fever toxin just the same as diphtheria. Instead of using Dr. Dochez's elaborate method we can simply use the Dick toxin. It looks as if scarlet fever would come to be treated and looked at much like diphtheria.

Measles.—Just a word on measles. Way back 30 years ago a German physician suggested giving convalescent measles serum at the beginning of a case to lessen the severity which it did not do altogether or earlier to prevent it. For the last five or six years it has been used more and more; and in Germany one physician used it on 1,000 children. It seems to me from our results at Willard Parker that it is a public health measure to have convalescent measles serum on hand for any physician and for all institutions and so we arranged to get a quantity of serum and we arranged to give it out generally. We found a great deal of difficulty in getting enough convalescent serum. So few adults have measles and generally when you come to the adult to get his consent, his wife or sister has persuaded him that they were anemis and should not lose blood. We found our best results were in the hospital. We have it at our Bureau office where any physician can get it for any child which has been exposed for not more than five days and for any child that is sickly. We use it especially for institutions. If you give the serum after about six or seven days, you may develop this very slight attack of measles without coryza. In no institution where this has been used has pneumonia followed any outbreak. The other day a friend of mine was going abroad. One of his children had developed measles. The other child had been thoroughly exposed. The child was given 10 c.c. of convalescent serum and he went on the voyage, no harm being done. Many times some sickly child which should not have measles will be saved from pneumonia, from ear trouble and various things.

Diseases of Adults Which Shorten Life.

During 1923 the principal causes of death in Brookline, Mass., were:

*Diseases of the heart, 112; *cerebral hemorrhage (apoplexy), 57; cancer, 56; pneumonia and influenza, 44; *diseases of arteries, 26; *diseases of the kidneys, 22; diabetes, 16, tuberculosis, (all forms) 10; total, 342; all other causes, 127. Total deaths, 1923, 470.

*"Wear and tear diseases."

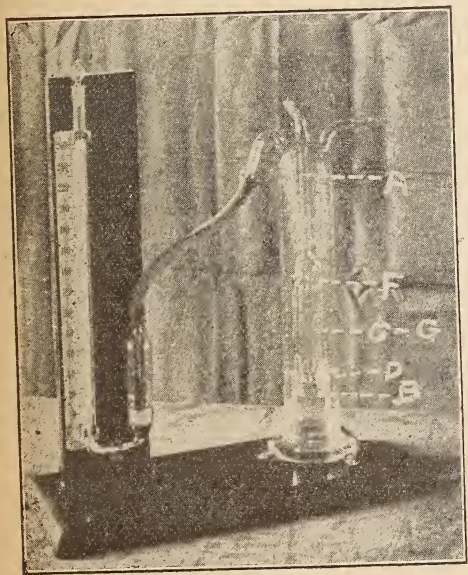
—Brookline Board of Health Bulletin.

TRANSUTERINE INFLATION OR THE RUBIN TEST.

By **James L. Cobham, M.D.,**

Jersey City, N. J.

Transuterine peritoneal inflation to determine patency of the fallopian tubes in cases of sterility was first introduced by Dr. I. C. Rubin of the Mount Sinai Hospital of New York, about five years ago. At that time, the apparatus used was crude and the method was attended with considerable danger. Today, however, these conditions are altered and the procedure, if judiciously used, is of the greatest value.



The Rubin apparatus enables the operator to measure the quantity and flow of gas used in insufflating the uterus to test the oviducts for patency. A manometer of the Tycos, or mercurial type, is combined with it, allowing for pressure reading at the same time the gas flows. This apparatus is of the pulsating type of water displacement meter and being of glass is non-corrodible and consists of an inverted syphon with a cylindrical glass meter. The later is calibrated to a given capacity—as a rule, 40 c.c. The operation of the meter is as follows: The gas enters through the tube "A," travels down the tube "G," then upward in tube "C" and the bell, or compartment "B,"

refills with water up to the upper end of "C." This completes one pulsation of the meter and is the capacity of the compartment "B," between the points "F" and "D," and the amount of gas flowing may be determined by counting the number of pulsations per minutes. The (pressure) pressure reading on the manometer is of the greatest importance and it has been found that the rate of flow is best regulated previous to a rise of 100 millimeters within 15 seconds; a faster rate than this in non-patent tubes may be attended with great danger.

The pressure required to overcome the resistance of the uterus and tubes where there is no tubal obstruction to the free passage of gas will vary between 40 and 100 m/m. When reaching these points it will fall sharply or slowly, or even fluctuate about them. Occasionally, the initial rise of pressure in the patent tubes will be higher and may reach 160 degrees before it drops. In the non-patent tubes, the pressure rises steadily to a point well beyond 200 degrees. When it is desirable to check up on non-patent cases, it may be done at the same sitting, when the flow is retarded, so that it requires 20/30 seconds to raise the mercury column to 100 millimeters.

Before going on with my paper, I will take the opportunity to mention the contra-indications of this test: They are arterio-sclerosis, myocarditis; eroded and infected cervix; the acutely anti-flexed uterus, with its concomitant tenacious plug of mucus, as well as any pelvic inflammatory condition accompanied by fever, pain, etc.

During inflation, the patient complains of more or less pain in the lower abdomen and this is more marked in those suffering from chronic inflammatory conditions about the uterine appendages. The more serious and extensive the lesion, the more severe is the pain. Women having completely closed tubes frequently complain of excruciating pain. The pain ceases, however, when the gas is withdrawn. Another type of pain coming on after inflation, when the woman has been placed in the sitting posture, is the result of a subphrenic pneumoperitoneum and is located always in the right shoulder, sometimes the left shoulder, or in both shoulders and upper abdomen. This pain is pathognomonic of patent tubes.

The use of the fluoroscope to determine

the presence of gas in the pelvic cavity is not necessary and is not used as a routine in the Mount Sinai Clinic.

An interesting series of experiments were carried out at the Michigan University, by Paterson and Cron, to determine the method of passage of the carbon dioxide gas through the tubes. The patient, under anesthesia, a medium incision was used. The intestines were carefully packed off and the posterior cul de sac was filled with a normal salt solution. The gas was then introduced in the usual manner and it was found in unobstructed tubes a bubble or bubbles arose during the first inflation and usually at a low pressure. In the obstructed tubes, depending on the type and location of the obstruction, the gas did not pass at all, or only at a high pressure—above 200 m/m of hg., and then only after repeated attempts. In some of these obstructed tube cases, the pressure was run as high as 300 m/m of hg. and the apparent obstruction was overcome and gas appeared at one or the other fimbriated extremity.

The fallopian tubes may be divided into two portions,—the isthmus or narrow portion, which begins just outside the uterus and runs through it, and the larger ampula, which terminates in the abdominal ostium and is surrounded by the fimbria. That the obstruction in most cases must have been in the isthmus, is shown by the fact that the fimbriated extremity was open and allowed the passages of a probe down to the isthmus portion. Many causes for obstruction in the isthmus have been advanced and among them are the mucus plug blocking the tube, but no plug has ever been seen at the Michigan Laboratory, and hundreds have been examined, so this cannot be considered a satisfactory explanation; tortuosity of the tube has been considered, as well as hypertrophy of the mucosa with polyp formation, but are very remote.

The logical explanation is chronic infection, involving the submucosa and proliferation and narrowing of the lumen of the tube and the narrowing may be so marked that the lumen is diminished from 1/5th to 1/20th of its size. However, complete closure of the tube at the isthmus portion has never been demonstrated in the laboratory and in those cases where the closure was complete it has always been at the fimbriated ex-

tremity. The most likely cause of complete closure at the fimbriated end is gonorrhea. These sealed club-shaped ends prevent the ova from reaching the uterine cavity, although the lumen may not be obstructed to bar the upward passage of spermatazoa. Unfortunately, we are unable to determine, clinically, whether we are dealing with an obstruction or a closure at the fimbriated end of the tube.

Another group of cases are those in which the abdominal ostium is not closed by inflammation but is shut off by adhesions and in many of these cases, when gas is sent in and the pressure raised to 200 m/m of hg., or slightly above it, the tubes once again become patent. It is thought the gas is liberated by separation of the adhesions or rupture of the infundibulum and repeated inflations may be required to accomplish this result. When rupture takes place it occurs at the weakest point and this is one cubic millimeter from the closed fimbria. The opening is small, but enlarges with repeated inflations. It is also felt in many cases where the lumen at the isthmus is narrowed it is dilated enough to permit the upward progress of the spermatazoa and in other tubes occasionally the fimbria of mildly adherent tubes are separated.

Uterine insufflation has also been used in cases of dysmenorrhea, and some uterine displacements, with good success, but as yet these are still in the experimental stage no more will be said about them in this paper. The following are a few cases from a series of about sixty that I have inflated at the Mount Sinai Dispensary and are of the open and closed type:

Mrs. A. G.—Age, 24 years.

Fam. Hist.—Negative; previous history, negative.

Menst. Hist.—First at 17 years; moderate amount; 28-day type and regular.

Marital Hist.—One husband; married 3 years; no miscarriages.

Present Illness.—Complains of heaviness in lower abdomen for several years; she cannot stoop over or lie down without acute pain in region of rectum. Had some headache and frequently, anorexia. Suffers from leucorrhea and frequency of urination; no burning.

Physical Exam.—*Abdomen*—Small umbilical hernia. *Vulva*—negative. *Vagina*—Moderate cystocele. *Cervix*—Negative.

Uterus—Anti-flexed—hard, normal size, freely movable. *Adnexa*—Right ovary prolapsed and distinctly palpable.

Rubin Test.—March 11th; mercury rose to 40-60 m/m in four pulsations; tubes patent.

Mrs. T. W.—Age 23 years.

Fam. Hist.—Mother died of heart disease at 42; one brother suffering from tuberculosis, at present a patient at Mount Sinai Hospital.

Menst. Hist.—First at 15 years; 28-day type; 7 days' duration; profuse; severe pain before onset.

Marital Hist.—One husband; married 5 years; two children; no abortions.

Present Illness.—Complains of severe pain in lower abdomen one day prior to menstruation. Sharp pain in rectum on going to stool.

Physical Exam.—*Vulva*—Negative; slight cystoectocele. *Cervix*—Bilateral laceration.

Uterus—Anti-flexed in retroposition. *Adnexa*—Both ovaries low down in cul de sac.

Rubin Test.—Mercury rose to 160 m/m and fell sharply four pulsations; tubes patent.

Mrs. Tillie C.—Age, 27 years.

Fam. Hist.—Negative.

Prev. Hist.—December, 4 years ago, Bellevue Hospital. Appendectomy.

Menst. Hist.—First at 15 years; regular; 28-day type; four days' duration; moderate amount; no pain.

Marital Hist.—One husband; married nine years; no pregnancies.

Prest. Illness.—Sterility.

Phys. Exam.—*Vulva*—Negative. *Vagina*—Negative; small mulliparous pointing forward.

Uterus.—Anterior angle between fundus and cervix obliterated. Uterus sharp anti-flexed.

Rubin Test.—March 11th, 200 Hg; March 13, 200; March 15th, 200 m/m Hg.; four pulsations. Referred to Mount Sinai Hospital.

Mrs. R. S.—Age, 27 years.

Fam. Hist.—Mother died at 45, diabetes.

Pres. Hist.—Operated on at Mount Sinai Hospital 8 years ago; appendix; influenza, 3 years ago, Mt. S. H.

Menst. Hist.—First at 11 years; regular; 28-day duration; 4 to 5 days; profuse; no pain.

Marital Hist.—One husband, 4 years.

Present Illness.—Sterility.

Local Exam.—*Vulva*—Negative. *Vagina*—Negative. Cervix normal in appearance.

Uterus—Normal. Adnexa? Parametrium, short and thick, no tender.

Rubin Test.—Dec. 10, '23, 200 m/m Hg.—No shoulder pains. Dec. 12, '23, 200 m/m Hg.—No shoulder pains. Dec. 28, '23, 20 m/m Hg.—No shoulder pains. Dec. 31, '23, 200 m/m Hg.—No shoulder pains. Mar. 14, '24, 200 m/m Hg.—4 excursions.—(Referred to Mt. S. H. for plastic on tubes.)

Mrs. M. W.—Age, 35 years. (colored).

Fam. Hist.—Negative.

Prest. Hist.—Appendectomy 12 years ago, Bellevue Hospital.

Menst. Hist.—First at 14 years; 28-day type; 3 days' duration; no pain; moderate amount; 4 children; one abortion. Lately periods have been lasting 7 to 9 days, when formerly about three, and she passes clots.

Present Illness.—Complains of pain in pelvic region, which travels up abdomen to epigastrium and then radiates to spine. Complains of nausea at height of the pain.

Phys. Exam.—*Vulva*—Negative. *Vagina*—Negative. Cervix, large hypertrophic, soft slight laceration.

Uterus.—Anti-flexed, enlarged, symmetrical; size of 8 weeks' pregnancy.

Adnexa.—(?)

Rubin Test.—Feb. 24, '24, 200 m/m Hg.—4 excursions. Feb. 26, '24, 200 m/m Hg.—4 excursions. Mar. 13, '24, 200 m/m Hg.—4 excursions.

Diagnosis.—Sub. mucus fibroid—Closed tubes.

PREVENTION, REHABILITATION, AND MEDICOLEGAL ASPECTS OF SPRAINED BACK.*

By John N. Bassin, M.D.,

Newark, N. J.

Associate in Orthopedic Surgery, Long Island College Hospital Medical College; Rehabilitation Surgeon, Newark Beth Israel Hospital; Former Chief Surgeon, New Jersey Rehabilitation Commission, and Medical Adviser to New York State Insurance Fund and New Jersey State Department of Labor.

In view of the abundant literature on the subject of diseases and injuries affecting the spinal column and contiguous tissues, this paper is limited to a practical consideration of the traumatic phases of sprained back with its multiple lesions as

*Read before the joint meeting of the American Association of Industrial Physicians and Surgeons and the Health Service Section of the National Safety Council, in Buffalo, Oct. 2, 1923. Received for publication Oct 5, 1923.

seen clinically in the rehabilitation and hospital clinics and workmen's compensation courts.

Physical rehabilitation of industrial workers by the state is a comparatively recent experiment. Morbidity statistics on the subject are either incomplete or entirely lacking. Steady progress is nevertheless being made, and information from various sources in the industrial and hospital field is gradually becoming more available.

Out of a series of several hundred so-called "labor backs" examined, the writer observed and followed to the initial surgical stage 456 such sprained backs. The sprain-fracture cases among those involved in sprained backs have been previously reported by the writer in a paper on "End Results of 442 Fractures Caused by Industrial Accidents."[†] In the present report, spinal sprain fractures observed in this instance are advisedly classed as of sprained back.

After comparing notes on similar cases of the non-compensable variety from the clinics and records of the Long Island College Hospital, and the Hospital for the Ruptured and Crippled, New York City, the writer was singularly impressed with the idea that this group of patients, seeking nothing but relief from pain and suffering, is actually more disabled than the objective clinical symptoms observed during the usual examination would warrant. Occasional negative x-ray and laboratory findings often contribute to obscuring disability unless one is on one's guard and examinations are repeated.

IMPORTANCE OF PROGNOSIS

In the final analysis, prognosis is the main asset of a compensation-rehabilitation scheme designed to save industry millions of dollars and to return the injured workman to his proper earning status.

When the neurotic patient and the malingerer are eliminated the character of the prognosis in sprained back is all the more significant, as there are no safety appliances thus far devised to prevent it. In estimating disability in compensation and negligence cases, prognosis is of greater importance than diagnosis, even though the latter is indispensable.

ETIOLOGY

Etiologically, the most back injuries are sustained in the course of gainful occupation requiring heavy lifting, or are caused by sudden spinal hyperflexion as a result of direct or indirect force. The young robust person usually suffers no more pain than

an acute spinal myositis—so-called strained back—would impose, in the course of several days' duration. When the accidental force is severe, the middle-aged worker whose back is thus involved is especially subject to complications and prolonged morbidity. Such workers are permanently incapacitated for their usual occupations, and their earning power is materially diminished. The problem becomes therefore complex both medically and socially.

These patients are seldom operated on by the open method, and as such cases never come to the postmortem table, more intensive clinical study is the only alternative, and prevention a paramount issue. To that end research is now being directed by Professor Jacques C. Rushmore of the Orthopedic Department of the Long Island College Hospital Medical College. All the other departments are co-operating with him in this work.

It must be conceded that so-called rheumatic diathesis, syphilis, tuberculosis,^(*) gonorrhea, pre-existing static weight-bearing deformity of the spine or lower extremities, or the ever-present focal infections are, singly or otherwise, contributory factors in cases of sprained back. Those organic conditions must, however, be diagnosed and treated early, or the patients, innocently unaware of danger, will continue their work without apparent disability until an accident occurs, and then preventive medical measures are at an end.

Whether the physician is now dealing with a new lesion or with an old one aggravated by the alleged accident, liability is established in the presence of a corroborative history. The patient himself is the pathetic figure as in spite of compensation he is a chronic invalid with all the suffering and economic waste that such a condition entails.

PATHOLOGY

Muscle and ligamentous tissue tears, capillary hemorrhage, round cell infiltration, and serofibrinous exudate constitute the minute pathological changes in the acute, and fibrosis in the chronic conditions. It is difficult to imagine how the nerve filaments, especially the organs of Golgi at the tendon insertions, escape injury. The muscle bellies are never reported as completely torn, but the muscle tissue contraction is soon impaired reflexly, first by stasis and later by unabsorbable fibroplastic deposits within the muscle and muscle sheaths around tendoperiosteal attachments and intervertebral spaces. The subsequent calcification and

osteophyte formation restrict spinal joint excursion rendering it more painful, as impaired muscle balance favors deformity.

The gross pathology of the later stage of back sprain, as evinced by laboratory and clinical findings, ultimately points to a chronic fibrosis and calcified deposits about the spinal column in the shape of excrescences or osteophytes.

Evaluation of the symptoms of fibrositis, fibromyositis and of periarthrititis, with or without accompanying joint involvement, is not difficult.⁽²⁾

SYMPTOMATOLOGY

The painfully weak back, the reflex muscle spasm of superficial layers and the actual rigidity of lower muscle planes, the distorted statics of weight-bearing, the angle of compensatory deviation at the hips in the sitting posture, the undue fatigue and the guarded gait and motions of the patients, who unconsciously seek hand or elbow support while sitting and lean while standing, are even more reliable signs than those entirely based on the degree of impaired spinal joint and muscle function. A forced mobile spine of this type is often debilitatingly painful, unlike a rigid poker pack which is not half so fatiguing and is much less discomforting.

DIAGNOSIS

In the cases observed, the following structures were apparently involved:

1. The musculotendinous segments of the Erector spinae group.
2. The tendo-periosteal attachments.
3. The ligaments and bone and joint tissue areas of the lower dorsal, lumbar and lumbo-sacro-iliac girdle.

The Latissimus dorsi was useful in evaluating tender points when the transverse, intertransverse, and interspinous muscle attachments were brought into play in the presence of a fracture of the spinous processes of the vertebrae. (This diagnostic feature is invaluable in the acute or subacute stages, if the patient is co-operating.) It was not unusual to note signs pointing to involvement of one or both sacro-iliacs, and the seldom mentioned and most often sprained lumbosacral articulation.⁽³⁾

There were some difficulty in establishing a diagnosis in cases where tendoperiosteal tears and joint loosening were present, though unrevealed by the x-ray until some time later as a periosteal thickening with an occasional deposit of an osteophyte which could not be distinguished from those seen in chronic spinal arthritis unless similar de-

posits were also present higher up on the spine or elsewhere about joints.

The pathognomonic signs of acute lumbar myositis, the pain, disability, tenderness and weakness ascribed to spinal strain often becloud this affection unless a painstaking differential laboratory diagnosis is made. Physicians treating these cases are often misled. They are chagrined to find that such patients turn up in the compensation courts for formal hearing months after the accident, with corroborative diagnosis of sprain fractures of one or more transverse or spinous processes of the lumbar vertebrae, a chronic fibromyositis, and a fibrosis often extending to the perineurium of the sciatic nerve, and all the earmarks of tangible chronic disability.

These errors not only contribute to the undermining of self-supporting citizens, but they also have the psychic effect of promoting malingering while the employer and carrier are unduly penalized by having to defray expenses for long periods of temporary disability and for permanent partial or total disability. It is therefore strongly recommended that all these cases be treated as serious spinal injuries until every element of doubt is eliminated. Expert advice at this time is invaluable.

Before coming to court, the physician should consider the effect of ascribing to an apparent pre-existing general or focal infection all there is to the case.⁽⁴⁾ He must keep in mind that a spinal arthritic is not necessarily disabled until along in years, and that the blood stream is constantly taking care of by-effects from focal infections except in cases where traumatism leads to the establishment of an area of diminished resistance and results in a fulminating lesion. The court usually ascribes such proven aggravation of a pre-existing disease to the accident.

Luxation of the lumbosacral articulation usually is less evident physically and may be as undiscernible by the x-ray as that of the sacro-iliac synchondroses. This involvement of the lumbosacral articulation is often misjudged because of the normally varying shearing angle at the promontory of the sacrum in different subjects, unless it is recalled that the lumbosacral joint is so placed that at best it bears the bulk of the strain of the entire body weight before transmitting it to the sacro-iliac and hip joints by virtue of the spinal muscles.⁽⁵⁾ This mechanical consideration is corroborated by the often overlooked crush fractures of this region.

PREVENTIVE MEASURES

Employees for manual labor should be selected carefully. A painstaking examination of the individual with emphasis on an x-ray of the spinal column, both laterally and anteroposteriorly should be made.⁽⁶⁾ The individual should provide himself with a suitable pelvic or spinal girdle support. The loose features of the average support can be overcome by a special pad over the lumbosacral articulation so arranged as to fill the space over the latter and the hollow of the back.⁽⁷⁾

Experiments conducted at the Long Island College Hospital seem to bear out the mechanical principle of relieving undue strain on the lumbosacral articulation by this special pad, which is equally useful as a preventive measure and as a supplement to curative measures. This adjustable pad and pocket arrangement tends to decrease the strain of the musculotendinous pull by diverting it to the pad, thereby conserving the integrity of tendon and ligamentous attachments in this vulnerable area.

REHABILITATION

Rehabilitation should begin immediately after the accident, and all patients with a definite history should be given the benefit of recumbent posture for at least five days, if possible, in an institution where laboratory facilities are at hand.⁽⁸⁾ At this time the ordinary myositis cases may become ambulatory with a daily treatment by massage for another three or four days, and usual work may be resumed in ten days to three weeks with the aid of the protective girdle support.⁽⁹⁾

In true sprain-back cases, however, the spine must be immobilized in a plaster of Paris jacket for fourteen days. The jacket may then be removed each day for a long enough period to allow treatment by physiotherapy. After this has continued for a month the jacket should be discarded and a permanent spinal support applied. At this time functional re-education holds out the best promise of minimal final disability.

In some of these cases electrotherapy was tried previous to the application of plaster of Paris jacket.⁽⁷⁾ A suitable electric modality has the effect of contracting the engorged tissues and forcing out the accumulated fluid, round cells, and other degenerative waste by way of the lymphatics. This electric treatment was preceded by thermotherapy, the alpine lamp or baker, a process that tends to relieve musculospasm and pain by dilating the capillaries.

The sedative type of electrotherapeutic

modality, including diathermia, was successfully applied in the subacute and chronic stages of the last 100 cases treated at the Newark Rehabilitation Clinic.⁽¹⁰⁾

If a fracture is eliminated and a tendoperiosteal tear is suspected, the treatment must be supplemented by a plaster of Paris jacket. Finally, functional re-education and vocational training suited to the patient should be pursued for two to three months. The patient may then gradually resume his work with the aid of a protective spinal support.

Whatever the outcome of the sprained back, the majority of these patients must have a suitable back support, since they are always subject to an unusual degree of fatigue.⁽⁸⁾

Physiotherapeutic measures are of little value when the sprain untreated has reached the secondary surgical stage. Much more drastic surgical means must now be resorted to. In fact, these secondary stage cases were the only ones available when "State Rehabilitation" was first pioneered in the clinics of Newark and Jersey City in 1919, 1920, and 1921. It was at that time, while operating on the first 200 cases for correction of deformities, that the writer was especially impressed with possibilities of prevention in the initial surgical stage of all industrial injuries, especially those affecting the spine.

Fortunately, there are now definite signs of progress in the industrial field. Less than half of the patients applying for final awards require further physical rehabilitation, whereas 76.3 per cent. of the author's first 1,000 cases examined for the State of New Jersey were in need of such treatment, and 44.2 per cent. were fracture cases requiring further reconstruction.

MEDICOLEGAL ASPECTS

It may be kept in mind that in some states the physician's estimate of a patient's disability is based primarily upon impaired function in relation to earning power (vocational); in others, upon impaired function in relation to usual or general manual labor. Functional impairment of sprained back should, if possible, be calculated in physical units of tangibly impaired structures.

Pain, although a subjective sign, is an element of disability in sprained back, and provided neurosis, hysteria, and malingering are eliminated, cannot be disregarded in estimating compensation.

Much confusion can be avoided if the physician leans more to the medical and

less to the legal aspect of estimating disability; but in the final analysis, in the words of the late New Jersey Commissioner of Labor, "The fact that a man is compelled to work when he is actually suffering pain as a result of an industrial injury to his back does not mean that he is able to work."

The estimate of functional disability must be viewed in the prognostic light of restoration of normal function, which clinical experience proves "possible." An estimate based upon clinical experience in cases of sprained back is quite different from an estimate on the basis of probability.

A hypothetical consideration is of value only when based upon actual experience of the medical witness or upon a description of the tangible lesion in relation to the symptoms in terms so simple that the average layman can understand them. Otherwise, it is usually discarded by the referee, at whose discretion the final award is allowed.

CONCLUSION

A sprained back points to a solution of tissue continuity by tearing of soft tissues, joint luxation, and occasional sprain fracture in the lower spinal and pelvic girdle region.

It is largely preventable in industry, through medical and mechanical means. The wearing of a pelvic girdle support to prevent "labor back" should be obligatory for all those engaged in manual labor.

Early diagnosis and treatment in the initial surgical stage is the only economical kind of rehabilitation. Sooner or later this must supplant all other physical means which experimentally precede the true or vocational rehabilitation of sprained back.

As a preventive as well as a curative measure, the element of fatigue should be guarded against by applying suitable lumbosacro-iliac supports while the patients are being treated and after they are discharged.

Prognosis is of great significance in the workmen's compensation or "negligence" cases of sprained back when such come up for final adjustment.

1. See Jour. Med. Soc., New Jersey, 1921, 18, 115.

BIBLIOGRAPHY.

1. Sever, J. W.: Diagnosis and Treatment of Disabilities of the Back. *Nation's Health*, 1921, 3, 98.
2. Hare, H. A.: Clinic at Jefferson Medical College Hospital, Sacroiliac Strain. *Therap. Gaz.*, 1920, S. 3, 36 (Whole S. 44), 542.
3. Hamill, R. C.: Case of Focal Infection Complicating Back Injury. *Internat. Clin.*, 1920, S. 30, 3, 127.
4. McCrae, T.: Clinic at Jefferson Hospital.

Sacro-Iliac Joint Disease. *Med. Clin. No. America*, Jan., 1921, 4, 982.

5. Epstein, S.: Backache. A Consideration of Low Back Pain of a Mild Type. *Med. Rec.*, 1921, 99, 734.

6. Crain, R. B., and Slater, B. J.: When Are Disabilities of the Back Arising out of Pathological Conditions Reportable Accidents? *J. I. H.*, 1921-1922, 3, 197.

Miel, G. W.: Arthritis—Sacroiliac and Lumbosacral: Usual Types Due to Overstrain. *Colorado Med.*, 1921, 18, 146.

7. Clark, W. I.: Our False Standards of Disability in Industry. *Nation's Health*, 1921, 3, 564.

8. Gottlieb, A.: Physiotherapy in Back Sprains. *Jour. Bone and Joint Surgery.*, 1923, 5 (Old S. 21), 339.

9. Cooley, L.: Static Back Trouble. *Illinois Med. Jour.*, 1920, 37, 195.

10. Personal Communication, 1923.

† See Jour. Med. Soc., New Jersey, 1921, 18, 115.

PRESIDENTIAL ADDRESS.

By Marcus A. Curry, M.D.,

Morristown, N. J.

Address of Dr. Marcus A. Curry, Superintendent State Hospital, Morris Plains, President of the Alumni Association of Albany Medical College, Delivered before the Association at Saratoga, New York, June 9th, 1924.

I deeply regret that the press of other matters has prevented me, during the past two years that I have had the honor of being your president, from devoting the full measure of time to this high position to which I feel that it is justly entitled. Despite my own deficiencies, however, I have enjoyed my term of office and have found most helpful and inspiring the contacts with the Trustees, the Dean, the Faculty, and the Alumni. In most cases, I fancy, it is a prerogative of older graduates of any institution of learning to feel that somehow their alma mater is not quite what it was when they were undergraduates, but if any of you are secretly cherishing such views, I heartily recommend a term as President of the Alumni Association. It will prove a complete and final corrective for such distortion of vision.

By way of a valedictory this afternoon, I have no carefully prepared scientific paper for your delectation. I have simply jotted down, more or less at random, a few topics upon which I feel strongly, and which though feebly expressed seem to me to have a real value for your consideration.

The general practitioner has certain advantages over the specialist. For one thing, he knows his patients up and down, through and through, root and branch. He

knows the entire family group—I am speaking of the man whose practice is located in a rural community or small city—he assists the various members into the world, cares for them through all their minor and major illnesses, observes and associates with them in their work and play, and acts as counselor, not only in the primary matters of health, but often also along other lines where wholesome advice is asked or required. Through this intimate relationship, he is in a position to gauge the resistance or weakness which furnishes the individual background in every case, both the physical constitution and the type of mental reaction to be expected. As a result, the family doctor either consciously or by instinct treats the patient in every case, with only a secondary interest in the type of disease itself.

With the modern development of specialists, laboratory methods, and scientific technique, the personal element has been too frequently lost to sight. Each patient is a case, with only the superficial background given by a rapid-fire system of "history" questioning. If his skin lesion is cured by the proper specialist, he goes to a different man for gastritis, and to a third for rheumatism. Each physician sees only the small section of the patient, so to speak, in which he is directly interested, and naturally is inclined to ascribe good results to the type of treatment, and lack of success to some failure in following instructions. Do not think for an instant that I am discrediting either the specialist or the laboratories. The tremendous advance in medicine in the last fifteen or twenty years, demonstrated by the lowered death rate in all sections, is almost entirely due to laboratory research and the efforts of specialists, and even the most remote general practitioner must acknowledge his debt to their untiring efforts, as they delve into the causes of diseases, work out the best methods of treatment, and then spread abroad with absolute unselfishness the results they have so painstakingly achieved. What I am trying to express is the fact that we are now in danger of forgetting the person in treating the disease.

Impersonal mass handling of human beings is rarely successful. Some years back we thought we had solved infant mortality problems for dependent children by establishing a perfectly balanced hospital routine of diet and general care. After a time, however, we discovered that the perfect schedule failed to produce perfect results. For some reason, the infants who received

more faulty treatment, but plus more personal interest and affection, did far better. From this starting point has been developed the whole child placing system, which has revolutionized the care of dependent children. Individual attention, with an understanding of the personality involved, is the keynote of treatment, whether the patient is in infancy or old age, whether the disease is classified as mental or physical.

In the newspaper discussion of a recent criminal case, one editorial writer in a prominent publication took the attitude that the blame for the crime must rest on the psychiatrists, if they were possessed of knowledge which could be used to prevent the development of such criminals and had not informed the public. From this standpoint, the physicians must now be held accountable not only for the presence of physical disease in the general public, but also for the presence of moral depravity. Absurd as this seems, it contains a germ of truth.

Perhaps there seems to be no relationship between my opening remarks and the discussion of crime prevention, but I feel that every physician who comes in contact with patients at all, if he is to achieve the highest success, is called upon to treat the mind as well as the body. Preventive medicine is already fully accepted in many fields. Public health and sanitation, school inspection, and the elaborate systems of medical care of employees which have been developed by many of the large industries and business firms are conspicuous illustrations of a general trend. All these agencies and many more, are doing their part toward educating the people and establishing the ideal of bodily health by prevention of illness. But in the field of mental hygiene, preventive work is less easily understood. In certain centres child guidance clinics have been established. Here and there, especially in the larger cities, mental hygiene clinics are maintained, usually in connection with some state or city psychopathic hospital. But the work now being done cannot even scratch the surface of the problem. It is almost impossible for a psychologist or psychiatrist to read a current issue of a newspaper without recognizing in some reported incident the evidence of mental obliquity. But unless such a person commit a major crime or become incapable of self-support a psychiatrist is rarely consulted. It is a law of present conditions, however, that sooner or later most people have cause to visit some physician. If this physician in-

studying the case gets at the chief points of personality—as he should in order to prescribe suitable treatment for the physical condition—and discovers that a well marked abnormality is present, then he is in a position either to furnish wholesome advice himself, or to direct the patient to the nearest neurologist, psychiatrist, or clinic where proper treatment is to be had.

Those of you who have been fortunate enough to come into contact with Doctor Amsden realize that he is our greatest authority on the subject of the analysis of personality. He has devoted years of careful work to evolving a simplified system upon which to base the study of a personality, with a view of ascertaining the settled behavior policies of the individual. Although such a painstaking and thorough analysis is usually possible only in the treatment of a psychotic patient seeking medical advice for his mental condition, yet some more or less rough and ready standard for estimating the reaction of the patient toward himself and his surroundings should be included in every physical examination.

Last year I told you something of the methods of treatment in a modern hospital for mental diseases, and mentioned briefly the preventive work which is being carried on outside the hospital walls by means of social service organizations and clinics. To-day I wish to urge closer co-operation between physicians in general and psychiatrists. We are all working for the public health and sound minds and sound bodies, irrespective of the particular phase which our specialty leads us to stress. And just as a thorough physical examination with correction of any observed lesions is an important step in the hospital treatment of a mental patient, so it seems to me that an understanding of the mind and recognition of any abnormality are vital to a satisfactory supervision of the physical health. If you are in doubt, call in a psychiatrist as consultant, just as you would call in a surgeon or a gynecologist. The normal mental development of the child and the maintenance of social efficiency in the adult are quite as important as the cure of appendicitis and the avoidance of smallpox. And, above all, do not wait until the damage is done before you take any action.

Time to Leave.—Lecturer—"Allow me, before I close, to repeat the words of the immortal Webster."

Hayseed (to wife)—"Land sakes, Maria, let's git 'out o' here. He's a-goin' ter start in on the dictionary."—Princeton Tiger.

THE TIMING OF INSULIN DOSES.

By **Frederick M. Allen, M.D.,**
Morristown, N. J.

The original plan of giving insulin just before meals is followed as a routine by most physicians, and works well in most cases. Difficulties are encountered, however, in certain severe cases requiring high dosage. In these there is a tendency to glycosuria or undue hyperglycemia before or after breakfast, and to hypoglycemia in the latter part of the day. Devices of increasing or decreasing the total dosage or diet, or altering the quantities of individual meals or doses, are still baffled by one or the other of these dangers. A fourth dose during the night is successful, but inconvenient. Accordingly, many practitioners resign themselves to the inherently bad and dangerous system of permitting glycosuria during at least a part of the day, feeling that this is at any rate the lesser of two evils.

Time of Doses.—In rare cases, the diabetes may be so severe that four doses during twenty-four hours are unavoidable. But for cases of any ordinary severity, there is need of a method by which a conscientious physician can accomplish the purpose of preventing glycosuria or extreme fluctuations of the blood sugar with three doses a day. These fluctuations are due to the cumulative effect of the doses of insulin during the day and the long period without insulin during the night. It is unnecessary to have recourse to the expedient (usually inconvenient) of giving breakfast extremely early and supper extremely late. Insulin is concerned not merely in the disposal of food during the digestive period but also in its utilization throughout the twenty-four hours. In the type of case mentioned, the long night period can be shortened by giving the first insulin dose about an hour before breakfast (usually immediately on rising) and the third dose about an hour after supper or even at bedtime. The first dose reduces the morning hyperglycemia, so that glycosuria does not occur either before or after breakfast. The cumulative effect of the morning and noon doses always prevents glycosuria at supper time. The evening dose, when postponed, does not augment this cumulative effect so as to cause hypoglycemia, but serves instead to repress the hyperglycemia which tends to develop during the night. The quantities of the single meals or doses can, of course, still be varied to suit the individual need or convenience of the patient.

Results.—In some six months' use of this plan, we have encountered no serious hypoglycemia or other difficulties, and we are therefore adopting it as a routine for most severe cases requiring high insulin dosage.

INTERESTING CASE OF PER- NICIOUS ANEMIA.

By Clarence L. Andrews, B.S., M.D.,

Associate Medical Chief Atlantic City Hospital;
Visiting Pathologist Bamberger Seashore
Home and Jewish Seashore Home.

Atlantic City, N. J.

Pernicious anemia, so-called because of its characteristic blood picture, unfortunately directs the physicians attention unduly to the red blood cell changes alone, and often makes him forget, I am afraid, that there are just as profound changes which take place in the digestive system, the circulatory system and the nervous system as those which occur in the red blood cells themselves. Moreover, these symptoms tend to occur earlier in the course of the disease and if properly observed should at least suggest to the doctor the possibility of on-coming pernicious anemia. Furthermore, if suspected and treated in this early stage, should offer to the individual, so suffering, his greatest chances of relief and possibly a cure. These disturbances usually occur in the following order: Digestive disturbance, frequently spoken of by the patient as indigestion and gastric analyses, which show the absence of free hydrochloric acid with a resultant diarrhoea. Secondly, disturbances of the nerve endings of the fingers and toes, complained of as numbness and tingling at these points. Thirdly, circulatory disturbances like haemic and functional murmurs, without apparent cause, with low systolic blood pressure. The heart conditions, may later become chronic as the disease progresses and ultimately lead to a myocarditis. Finally, the characteristic blood picture of low red cell count; high color index and enucleated and distorted red blood cells.

The above facts have been spoken of by others in recent years, yet in discussing and hearing discussed the characteristics of this disease from time to time, the blood picture alone is put in the foreground as the chief finding. Very few speak of the early gastric disturbances, the early nervous manifestations and the circulatory changes mentioned above. It reminds one of a great tendency in many to hesitate to call a case of unquestionable lung consolidation pneu-

monia because of the absence of cough and rusty sputum. As illustrative of the great importance of carefully following up all cases who show an absence of free hydrochloric acid in the stomach and tingling and numbness of the finger tips and toes, notwithstanding a normal blood picture, the following case is reported. This case was first seen by me two years before any blood changes, to speak of, had occurred and was followed systematically for four years later through all the stages of development when he finally died quite suddenly of what appeared to be acute cardiac failure, undoubtedly due to degenerative myocardial changes spoken of above—there was no post mortem.

Report of Case.—Male, age 52, author, writer and lecturer by profession, who was first seen by me March, 1915, complaining of indigestion and inability to eat what he formerly ate, with occasional attacks of diarrhoea and weakness. His family history was negative except his father died of malignancy of the stomach at the age of 46. His personal history was unimportant as he had always enjoyed splendid health and rather prided himself in keeping well and for always seeking medical advice before allowing any disturbance to linger. He was married and had one healthy daughter, age 18.

His present illness began the latter part of 1914, following the tremendous nervous strain incident to the European War, as he was of German extraction. He was somewhat depressed, had no appetite and felt heavy in the stomach after he had eaten—particularly when he ate meats, with an occasional attack of diarrhoea. There was no pain, nausea or vomiting, but some loss of weight due undoubtedly to decrease in food intake. He was put to bed and upon examination showed the following: A rather well nourished, well kept male with nothing especially to be made out except that he was somewhat apprehensive about himself; some increase in the deep reflexes with low blood pressure 115-89, pulse .84. Urine normal, blood analysis showed slight secondary anemia as follows: Hb., 85%; R. B. C., 4,200,000; W. B. C., 7,400; differential not done.

The chief point of interest was in his gastric analysis which showed no free hydrochloric acid with a deficit of 13 or .047%. He was given dilute hydrochloric acid by mouth, cacodylate of soda hypo. and in three weeks he showed a remarkable change. He felt quite normal, could eat a normal

diet, gained in weight and his blood picture was as follows: Hb., 92; R. B. C., 4,900,000; W. B. C., 7,500. He left the hospital and resumed his work.

About six months later he returned again complaining of his former symptoms, but somewhat intensified with slight tingling of finger tips. Gastric analysis showed again a deficit of .05% and his blood picture again about as when he first entered. On account of tingling in his fingers, a differential blood count was done and a search made for nucleated red cells. The differential showed nothing of importance and there were no nucleated red cells found. He was put to bed; given dilute hydrochloric acid by mouth cacodylate of soda hypo. and Bland Mass pills after meals. He again responded to treatment very nicely and soon began to eat, his tingling of fingers got better and he felt quite fit. Blood taken at this time showed Hb., 90; R. B. C., 4,600,000; W. B. C., 8,000. No disturbance in shape, no nucleated reds.

About one year later he came back again with a return of former symptoms somewhat more exaggerated, evidence of more anemia and tingling and numbness in both fingers and toes. Gastric analysis showed more of an acid deficit, .085%; Hb., 78; R. B. C., 3,500,000; W. B. C., 7,600; with some suggestive changes in the shape of the corpuscles and one nucleated red, but could not find any more. From the slight increase in color index, gastric symptoms, tingling and numbness in fingers and toes with a possible nucleated red cell, I felt I was unquestionably dealing with an incipient case of pernicious anemia. He was put on large doses of dilute hydrochloric acid, cacodylate of soda hypo. and Bland Mass pills, and the symptoms began to clear up; his gastric condition got better; his tingling got less and he gained in weight. In six weeks he seemed normal again. His blood picture went back to where it usually did again with no apparent disturbance in shape of red cells and no nucleated reds. He left the hospital and was told to keep up his treatment.

About ten months later he was seen again and it was quite apparent that he had not followed my advice. He showed that he was a sick man. He looked anemic, was somewhat yellow and had lost considerably weight. All of his former symptoms had returned with increased severity and he was greatly upset nervously. His blood picture now was unmistakably that of pernicious anemia; Hb., 60; R. B. C., 1,800,000; W.

B. C., 8,000; many nucleated reds and anisocytosis and poikilocytosis with tendency to vary in staining. He was again treated as before, but took a much longer time to respond, but eventually improved very greatly and his blood picture increased to Hb., 88; R. B. C., 3,500,000; W. B. C., 9,000; occasional nucleated red and some disturbance in shape. He left the hospital and apparently did well for about a year by keeping up the hydrochloric acid by mouth, when he died quite suddenly with, what the doctor who saw him called, acute cardiac failure. There was no post mortem done.

CONCLUSION.

1. All cases showing absence of free hydrochloric acid in the stomach, without apparent cause, notwithstanding normal blood picture should be followed up, and if followed by tingling and numbness of fingers and toes should put one on the outlook for blood changes to follow.

2. These cases apparently get over their trouble when treated at first, therefore should be kept constantly under surveillance and treatment.

3. Everything points to the fact that whatever the cause of pernicious is, the same poison which attacks the blood, attacks the digestive and nervous systems as well and that the blood changes are but a part of a general disease.

REPORT OF TWO CASES OF LEUKEMIA.*

By Aaron E. Parsonnet, M.D.,

Attending Physician Beth Israel Hospital.
Newark, N. J.

Looking through our hospital records of the past four years we found that no leukemias were admitted or at least diagnosed as such. This year, however, almost simultaneously two cases knocked at our doors and whether we were not entirely prepared for them, or due to our limited knowledge of treatment of this disease both of them soon left us. They died in a comparatively short time. Both of these cases were young, type of disease acute and each represented a different form. Because of the rarity of these diseases I thought it worth while to report them.

The first case is that of a male, 28 years old, born in U. S., fireman by trade, admitted to the hospital October 22, 1923. C. C. of pain in the left side and shortness of breath. His family history was entirely

*Read before the Clinical Society of Newark Beth Israel Hospital, May 7, 1924.

negative, absolutely no history of any blood disease. Personal history was also entirely negative, he always enjoyed good health and did not remember ever being ill. The present illness as told by the patient began about six weeks prior to admission to hospital. It started with a very annoying non-productive cough, also pain in the hypocondriac regions and over the pre-cordium, he also became very dyspneic. He lost his appetite, about 20 lbs. in weight and felt extremely weak. At first he had no chills, sweats or fever, but in the last week or two he perspired quite profusely at times. This condition became progressively worse and he entered hospital for treatment.

The physical examination revealed a fairly well nourished individual of about thirty, who did not look acutely or chronically ill. The head, eyes, nose and ears and mouth were negative. The neck revealed a moderate enlargement of all cervical glands which were rather soft in consistency. The examination of the chest showed quite a definite bulging of the entire left side. Expansion was limited while the intercostal spaces were entirely obliterated. Vocal fremitus was absent over the whole left chest. The same side on percussion was definitely flat. The right side was hyper-resonant. Breath sounds on affected side were distant, hardly audible. Over the right side breath sounds were broncho-vesicular at apex with crackling rales at end of inspiration. Examination of heart showed the apex beat not palpable and not visible, the heart was also displaced to the right. The sounds were distant but regular. The abdomen was negative, spleen not palpable. Extremities negative.

Adenopathy.—Besides the cervical glands,—the inguinal on both sides were also palpable. On admission a provisional diagnosis of pleurisy with effusion or pericarditis with effusion was made. The x-ray report was as follows: Effusion of left chest, heart enlarged, no pericardial effusion.

The patient was tapped and about 2,000 c.c. of fluid obtained under great pressure. The phys. signs however still showed a considerable amt. of fluid remained in his chest, but owing to fear of collapse of the lung no more was removed at that time. Examination of urine was negative. The blood examination, however, immediately revealed the nature of the disease that confronted us. On the date of admission the blood count was as follows: Hemoglobin 78%; Reds, 4,000,000; Whites, 70,000; of

which Polys, 10%; Lymphocytes mostly small, 87%; End, 1%; Eos, 1%; Bas, 1% Anisocytosis and Poikilocytosis present.

Several other examinations of the blood were made and they all showed a tendency to a gradual decrease in hemoglobin and red cell count until on November 16, just a few days before death the hemoglobin dropped to 60% and total reds 2,500,000, while the white cells increased very rapidly, reaching a count of 80,000. Dif., Polys.—2%.—Lymph.,—93%, End.,—1%, Eos.,—4%. The sputum was examined ten times and came back negative for T. B. The chest fluid was also examined for T. B. and found negative. The culture revealed nothing and the smear only showed many small lymphocytes. The Wassermann was neg. The stool proved neg. for parasites or ova but was positive for occult blood.

Course of the Disease.—After a few days at the hospital the glands of the neck became more pronounced and many petichael hemorrhages appeared on body and extremities. Slight bleeding from the mouth was noticed, patient began to look cachectic. Gradually the petichae became more numerous and took on an echymotic appearance. On November 4, patient had a severe coughing spell followed by hemoptisis. On that day temp. rose to 103 degrees. On the following morning large hemorrhages into the skin were noticed and a few hours later a severe nasal hemorrhage developed which continued for hours in spite of nasal packing, adrenalin, thromboplastin, applications and horse serum injections. It was somewhat checked by anterior and posterior nasal packing. Following this incident bleeding continued practically all the time. Hemorrhages from the mouth were almost a daily occurrence. Glands became very large but spleen was never palpable. Patient continued to grow weaker and on November 29, 1923 his struggle was over. Although the treatment was mostly symptomatic we tried practically everything recommended in medical literature. Large doses of arsenic in form of Fowler's solution were given. Iron compounds were administered, also benzol for a short time. He was also transfused with 500 c.c. of blood—but no procedure seemed to make the slightest impression on the acute course of the disease.

Case II. is that of a woman 26 years old, born in U. S., admitted to hospital December 14, 1923. Chief complaints on admission were (1) swollen glands and sore gums; (2) pain in epigastrium. Family

history was negative except that one brother died of cerebral hemorrhage at the age of 27. Her previous history was also negative, except for occasional headaches and dizziness. She was operated for appendicitis two years ago. Her menstrual history normal. She was married four years, had one child two years old, and never miscarried. The present illness dated back to about three weeks previous to admission, when she began to experience pain in the epigastrium, the pain was constant, did not radiate, and had no relation to meals. Thinking these pains were caused by her teeth, she consulted a dentist first, who promptly referred her to a physician. The latter advised her to enter the hospital at once.

Physical Examination.—This revealed an adult female about 26 years old of a rather pale and puffy complexion, but otherwise she did not look acutely or chronically ill. The head was of normal shape and contour, but for two small masses over each temporal bone just above the mastoid processes,—they were soft in consistency and not circumscribed. Examination of the eyes showed the conjunctive pale and a few petichial hemorrhages. Both pupils equal and regular, and reacted to light and accommodation. A few days later marked retinal hemorrhages were observed under the ophthalmoscope. Nose and ears negative. Examination of mouth.—A very foul odor was felt. The lips were pale, tongue moist and slightly coated—mucous membranes were also pale and a few petichael spots present. The gums were quite swollen and the left one, surrounded by a large gangrenous area, showed a distinct ulcer. The throat and tonsils were markedly congested. On the neck many ant. and post. cervical glands were palpable. These were soft in consistency and varied in size from a pea to a hazel nut. Some were quite distinct while others seemed matted together. The maxillary glands were also palpable and soft, the thyroid was not enlarged and no pulsating vessels visible. Lungs and heart negative.

Examination of Abdomen.—A midline scar from previous laporatomy observed. Tenderness of epigastrium directly in midline was present. The spleen could be easily felt about one finger below costal margin. No perisplenic friction rub was heard. A large mass occupying the right lumbar region was also observed. It was irregular in outline, soft, quite tender to pressure

and did not move with respiratory excursions.

Extremities.—Ankles were edematous and a few petechiae present. No bony tenderness, and reflexes negative. A marked general adenopathy was present. A provisional diagnosis of leukemia or Hodgkins' disease was made. Examination of urine showed albumin and casts. Examination of the blood as in the other case revealed the exact nature of the condition we were confronted with. On the day of admission it was as follows: Hemoglobin, 64%; R. C., 3,140,000; W. C., 170,000. Differential: Polys., 6%; Lymph., 24%; End., 34%; Eos., 3%; Myelocytes, 33%. Marked anisocytosis and Poikilocytosis was observed. An oxidase stain corroborated our findings revealing the exact nature of the abnormal cells. Several subsequent counts made showed a steady and rapid decrease in hemoglobin and red cells. A few days before death hemog. was 20% and total reds 1,280,000. While the white count changed little the myelocytes increased enormously, reaching 74%. The last dif. count, oxidase stained: Myelocytes, 74%; Lymph, 24%; Polys., 2%.

Other Laboratory Findings.—Wassermann, neg. Stool contained occult blood. The smear from mouth showed definite vincentes spirilla. The course of the disease was very rapid,—patient began to run a very marked remittent temperature, at times it reached 105 degrees. The pulse and respiration increased correspondingly, at times reaching 150 and 50 respectively. She looked very sick and suffered a great deal of epigastric pain. The glands enlarged more and more and peticheal and echymotic spots became more numerous. The condition of the mouth at this time was appalling. The ulceration was now more wide-spread and exuded a very disagreeable odor which did not seem to yield to any deodorant mouth wash. The spleen continued to enlarge, patient's vision was blurred and her sufferings at this time were indescribable. This rapid course could not be checked by any means in our posession. X-ray therapy—a full dose was given, benzol was tried, salvarsan applied to ulcers, sodium cocadylate injected intravenously, but no drug or procedure seemed to have the slightest effect upon the progress of the disease. After sixteen days of practically constant suffering patient died. No permission for autopsy could be secured.

Looking over the literature of Leukemia, very little is found to throw additional light

upon the etiology or treatment of this group of diseases. As to the etiology there are two main views: (1) Some compare Leukemia to Sarcoma, and it is thought to be essentially a malignant manifestation of the blood and blood-forming organs. (2) Others regard the process primarily hyperplasia of the spleen and bone marrow, not in itself malignant though productive of changes incompatible with life.

Based upon these theories, attention is directed to some of the methods of treatment from which at least some relief has been obtained. The present status of treatment is mostly x-ray, radium and benzol. The technic of x-ray applications, numbers of exposures and areas used is left to the experienced Roentgenologist and is not in the domain of the internist. I will add however, that many report successful cases. Richards in the Journal of Radiology reports nine cases, six of which were still living three years after treatment, and four of which had practically normal blood counts. Upson in the American Journal of Roentgenology discusses the x-ray treatment of Leukemia and reports several cases who benefited for a comparatively long period by his method. Many report poor results with benzol.

The conclusion is simple: On the line of march of medical progress the treatment of Leukemia is still left behind, adding another problem for the future to solve.

3 Madison Ave., Newark, N. J.

EFFECT OF FREEZING ON DIPHTHERIA TOXIN-ANTITOXIN MIXTURES AS REGARDS TOXICITY.

Drs. John F. Anderson and George F. Leonard of New Brunswick, N. J., have a paper in the A. M. A. Journal of May 24th on the above subject, from which we give the following "Summary" and "Conclusions."—Editor.

Summary.—Fifteen lots of diphtheria toxin-antitoxin mixtures containing three L + doses of toxin, prepared with a highly refined globulin in which 0.3 per cent. tricresol was used as a preservative, showed no increase in toxicity after freezing.

Eight lots of diphtheria toxin-antitoxin mixture, prepared with a highly refined globulin, containing one-tenth L + dose of toxin, 0.3 per cent. tricresol being used as a preservative, developed no increase in toxicity after freezing.

Mixtures of diphtheria toxin-antitoxin

prepared as stated above became, on the average, less toxic after freezing.

Mixtures prepared with three L + doses of toxin, with 0.3 per cent. tricresol and made with an antitoxin that had been concentrated without the use of heat, showed an increase in toxicity after freezing.

Diphtheria toxin-antitoxin mixtures prepared with unconcentrated antitoxin with three L + doses of toxin, 0.3 per cent. tricresol or 0.5 per cent. phenol being used, increased in toxicity after freezing.

Diphtheria toxin-antitoxin mixtures prepared with unconcentrated antitoxin with three L + doses of toxin, chlorbutanol or chloroform being used, or without preservative, showed no increase in toxicity after freezing.

Diphtheria toxin, after freezing at minus 5 C. for forty-eight hours, showed a decrease in toxicity.

In the mixtures prepared with unconcentrated antitoxin containing three L + doses of toxin, with tricresol as a preservative, and subsequently frozen, there became disassociated approximately twenty minimal lethal doses of toxin.

This free toxin was neutralized by the addition of diphtheria antitoxin or the simultaneous administration of antitoxin, so that acute death was prevented; but paralysis and local reactions sometimes developed.

Conclusions.—In no instance was there found an increase in toxicity after freezing of diphtheria toxin-antitoxin made with a refined antitoxin or globulin, according either to the old or the new formula.

Freezing of a three L + dose mixture of toxin-antitoxin containing 0.3 per cent. tricresol, prepared with an antitoxin concentrated without the use of heat, resulted in an increase in toxicity of the mixture.

Freezing of mixtures of toxin-antitoxin made with unconcentrated antitoxin and containing three L + doses of toxin, in which tricresol or phenol is used as a preservative, results in an increase in toxicity of the mixture.

Freezing of such mixtures in which chlorbutanol or chloroform is used as a preservative, or in which no preservative is used, does not cause an increase in toxicity of the mixture.

Only highly refined antitoxin or globulin should be used in the preparation of diphtheria toxin-antitoxin mixtures.

Mixtures of diphtheria toxin-antitoxin containing one-tenth L + doses should be the only formula permitted.

County Medical Societies' Reports

BERGEN COUNTY.

The regular monthly meeting of the Bergen County Medical Society was held at the Hackensack Hospital, June 10th, 8.30 P. M.

The president, Dr. Edwards presided; about 55 members being present.

Dr. John Dickson, Bogota and Dr. Joseph P. Cleary, Westwood, were elected to memberships.

The speaker of the evening, Dr. Wm. Francis Honan, associate chief of the surgical staff of the Fifth Avenue Hospital, New York City, gave a very interesting and instructive talk, illustrated with lantern slides, on "The Indications For Radical Surgery in Gastric and Duodenal Ulcers."

After answering several questions, advanced by members of the society, Dr. Honan was offered a rising vote of thanks for his paper. The meeting then adjourned to a social session.

MERCER COUNTY.

A. Dumbbar Hutchinson, M. D., Reporter.

The meeting of the Mercer County Society, held in May, was devoted to the subject of Cancer.

The City Commission, through its Realth Department, made a very thorough survey of the physicians having cases of cancer under their care, during the month of May, in order to obtain data relative to the building of a hospital for the care of such cases.

Approximately 75 cases were reported as at the present time receiving the care of physicians, and in a large percentage of these cases the patients were more or less agreeable to hospitalization. The physicians expressed the opinion that such hospital was almost a necessity and would add greatly to the general comfort and relief of the patients. This aspect of the subject was thoroughly discussed by the members of the County Society, as well as the clinical manifestations, with prognosis and treatment.

June Meeting.

The June meeting was held in Proctor Hall of the Graduate College, Princeton University.

With the approval of Dean West and through the courtesy of Controller Wintringer, Dr. Schauffler was enabled to inform the Program Committee of this wonderful opportunity of convening in one of Princeton's magnificent halls of fame and culture.

Dr. David F. Weeks, superintendent of the Village for Epileptics, was the speaker of the afternoon.

His subject, "The Cause, Symptoms, Diagnosis, Prognosis and Treatment of Diabetes," was most entertainingly discussed; Dr. Weeks seemed to have the happy faculty of not only presenting this large field in a most convincing manner, but choosing his words in such style as to be pleasing to hear and to entertain. Much interest was manifested by his audience in the general discussion that followed the address.

Dinner was served in the dining hall, a most beautiful room, surrounded by gorgeous colored windows and ancient woodwork of Grecian style and architecture.

Dean West pronounced the invocation in his usual Latin tongue, a custom that he has observed for many years.

Following a very delightful dinner, Dean West spoke a few words in praise of the rapid progress that the Profession of Medicine has made in the last decade, and also gave a very interesting description of the building of Proctor Hall.

The Society was honored with the presence of Dr. D. C. English, who responded to the call for a few words in his usual eloquent and delightful manner.

MIDDLESEX COUNTY.

F. C. Johnson, M.D., Reporter.

A regular meeting of the county society, postponed one week to accommodate the speaker, was held in Queen's Building, Rutgers College, June 25th, at 4 o'clock P. M. President A. L. Smith in the chair with good attendance. Five members were added to the roll, secured by F. N. Standbridge, a worker under the A. M. A.; Drs. W. J. Condon, E. H. Eulner, reinstated, and Drs. W. J. Condon, A. A. Pansy and R. L. Cooley, new members.

A most interesting and instructive address was delivered by Dr. W. C. Clarke, Professor of Surgical Pathology in the College of Physicians and Surgeons, N. Y. City, on "Some Problems in Surgical Pathology," illustrated with lantern slides. He received a rising vote of thanks.

MONMOUTH COUNTY.

Harvey S. Brown, M. D., Reporter.

The April meeting of the Monmouth County Society was held in Thomas Inn, on April 30, at 8 P. M.

Dr. William H. Cameron of Pittsburg, Pa., read a paper on "Some Consideration in the Use of Radium." It was an exceedingly interesting and practical paper and a vote of thanks was extended to the doctor for his paper and for the long trip he had taken in order to present it.

The question of County Health matters, of special interest to our members, was laid over until the May meeting.

May Meeting.

The May meeting of the Monmouth County Medical Society was held at the Metropolitan Hotel, Asbury Park, on Thursday evening, May 29th, 1924, at 9 P. M. Dinner was served and the president announced that this meeting was a business meeting only and that no papers would be offered.

Discussion covered several matters of interest to county physicians. "A Uniform Minimum Fee System in the County"; "County Health Matters"; The Use of Medical Clinics by Those Who Can Well Afford to Pay For Treatment"; "Non-Co-operative Methods Between Social Organizations and the Physicians of the County." Steps were taken to adopt a uniform scale of fees in the county, similar to that in vogue in cities, and committees were appointed to devise methods of procedure that would not interfere in charitable work.

The meeting was well attended, and the subjects were freely discussed. The committee will report at the next meeting of the society.

The members present were: Drs. Campbell.

Wilbur, Bennett, Tilton, Fairbanks, Herrman, Fisher, Parry, Holten, Tripp, Warren, Brown, Strahan, Donovan, Ingling, Wilson, H. B. Slocum, Hartman, Cassidy, Beveridge, Mahar, Leighton, Kazman, McConnell, McKenzie, Lovett.

MORRIS COUNTY.

Marcus A. Curry, M.D., Reporter.

The regular quarterly meeting of the Morris County Medical Society was held on Tuesday, May 27th, at Shonglum Sanatorium, the Morris County Tuberculosis Sanatorium, by invitation of the management. President Dr. Hampton presided over the formal meeting of the society which was held on the solarium porch of the nurses' home.

The nominating committee made its recommendation of officers for the next year, to be voted on at the annual meeting in September. The method of selecting delegates according to alphabetical order made it necessary to defer these recommendations until after the annual meeting of the State Society next week, when it can be determined just who has had his turn. A radiant incident of the routine business was the report of Treasurer Reed, showing a balance of \$1,516.98 with no one in arrears; this happy situation brought much deserved laudation to the treasurer for his high standard of efficiency. The combination of financial opulence and the beckoning of a worthy cause, found its reaction in an unanimous vote of \$500 from the treasury to the Morris County Children's Home at Parsippany.

The more intimate business of the society being disposed of with dispatch, the meeting adjourned to meet in September, at the State Hospital at Morris Plains, upon invitation of Superintendent Dr. Curry.

This being an open meeting, upon invitation of the management of the Sanatorium there were many officials of the county present as well as a large group of men and women interested in tuberculosis work in general and in the sanatorium in particular.

The program of the day was Inspection, Luncheon and Addresses, and each guest of the sanatorium received from President Mr. Thomas W. Leonard of the Board of Managers or Miss Kathryn E. Dandley, superintendent, a set of photographs showing interior and exterior views of the institution.

A thorough inspection of the institution in all its components was made under the capable and affable chaperonage of President Mr. Leonard and Superintendent Miss Dandley. The inspection left no terms short of those of the superlative degree to describe the appointments and regime of efficiency so apparent everywhere; and the order of cleanliness just seemed to crystalize everything that has been said or can be imagined on the old familiar subject of "Spotless Town."

The patients in various stages of convalescence were all cheerful and eager to chat and one easily could sense the atmosphere of hope and happiness that pervades the sanatorium; and this being a condition that can spring but from one source, what more need be said for the efficiency from cellar to garret of the whole edifice of energy that controls—from the County Board of Freeholders, the Board of Managers and the Resident Superintendent.

Memories of our late colleague, Dr. A. E. Carpenter of Boonton, were brought fondly to mind when among the many details so deftly indicated by Miss Dandley, was pointed out the nucleus of an adequate medical library donated by our late member.

Inspection being over the members of the society and other guests of the sanatorium were served with a delicious and generous luncheon, a la buffet.

After luncheon, President Dr. Hampton of the society tapped his gavel and in a neat opening speech turned over the ceremonies to President Leonard of the Board of Managers. He put the assembled guests at perfect ease in a cordial speech of welcome and expressed his gratification at the exhibition of interest in the work, saying further that this was the third spring meeting of this kind at the sanatorium and each year has been more successful than the previous one; and while the weather was against us he could not help but feel that this was a very successful meeting. Reviewing the statistics, Mr. Leonard said that the per capita cost of the institution for 1923 was \$27 per week per patient; that while last year at this time there were 22 patients, today there are 34; that last week there were 37 patients, which is the limit of capacity, except for the dormitory on the third floor which can be used to increase the number to 50 patients; which census comparison shows that the outside co-operation in getting patients to the sanatorium is functioning better than ever before; last year the expense of the institution were \$37,000 and \$8,000 for permanent improvements, that artesian wells have been sunk and the water facilities improved so they now have plenty of water and also have installed an electric pump at the pumping station. This year the appropriation for running expenses is \$3,000, and \$4,000 for permanent improvements, the major part of which probably will be the improvement of the roads about the sanatorium. Mr. Leonard said it was gratifying to him that more patients were coming, considering that there is so much tuberculosis throughout the county; and that the sanatorium should be filled and have a waiting list as it is capable of doing much good. In order to draw a lesson of what people have at their very door and seem to fail to appreciate, Mr. Leonard related an incident that came to his notice recently in the mountains of Virginia where a little boy had T. B. with no facilities for care and treatment within many miles; compared to this, he said, think of what you have here and the only thing to do is to find the cases and bring them in; that it behooves everybody to make this effort and he hoped that all would take it upon themselves in this way to further the work of the sanatorium can do; that Superintendent Miss Dandley will be delighted to give information to anybody seriously interested in the institution and is ready at all times to have all friends of the institution come and go through and see for themselves at any time what we have and what the conditions are. Closing Mr. Leonard said that in connection with the advantages of sanatoriums, he would call upon Superintendent Dr. Curry of the Morris Plains Hospital, who had just returned from Mt. McGregor, to say a few words.

Dr. Curry said that while he would only take a few seconds to it, he was very glad to say a few words; that it was a little bit out of his line when he talked on tuberculosis as at the State Hospital they are interested in a different branch; that it was his privilege last Thursday to be at the opening and dedicatory exercises of the research laboratory at Mt. McGregor, a few miles beyond Saratoga, New York, which is a tuberculosis sanatorium ran by the Metropolitan Life Insurance Company, for their employees; that as he had said to Mr. Leonard, the point that struck him so forcibly was that if, from a sordid standpoint of finance, it is advisable for a corporation of any kind to run a sanatorium of the size at Mt. McGregor, how much more it should pay the county and state to run an institution or see that their employees in the various institutions are properly looked after and cared for; that during the past ten years at the Mt. McGregor sanatorium they have had somewhere about 5,000 patients and have turned out from 75 per cent. to 80 per cent. of recoveries, which is a lesson in economy in all that it means to that particular company and how much more would this be so to the county and state; continuing Dr. Curry said that it seemed to him that if we could back some such movement and could show what we are doing of that kind for county and state employees, how much more those employees would do for the patients that are coming under our care; and our turn over of employees is going to be so much less, as every time we discharge a person and bring in a new employee some one has to instruct the new employee and we are losing money in that turn over; if it pays a corporation to salvage their trained employees, how much more ought it to pay the county and state.

Director Abell of the Board of Chosen Freeholders and Mr. Fritts, chairman of the Hospital Committee of the Board, spoke in favor of these gatherings, and both stressed the need of alertness on the part of everyone to make the sanatorium and its work known to everyone and available to sufferers from tuberculosis; also the readiness of the freeholders who acted favorably on the demand for the institution at the time of its inception and their readiness to back it; but they did feel they owed a duty to the taxpayers to show that their money was being well spent; and this could best be shown by the functioning of the sanatorium to full capacity; and they would support enlargements if they be shown to be necessary, and incidents were mentioned where patients were neglected to be sent to the sanatorium.

The speaker of the day was then introduced, Edgar Thompson Shields, M.D., of New York, Medical Field Secretary of the National Tuberculosis Association.

Dr. Shields having been drafted at the eleventh hour to substitute for Dr. Linsley Williams, Managing Director of the National Association, prevented by illness from being present, spoke extemporaneously, eloquently and impressively; he covered a wide scope on the subject which he illuminated with many incidents to the point. Dr. Shields who but recently had made a tour of the sanatorium, in company with Miss Headley of the County Anti-Tuberculosis Society, said that he believed at Shonghum there was a nucleus of

a wonderfully fine work that the county should be proud of; that some people have a very hazy idea of what a sanatorium means; that it is neither the beginning nor the ending nor the whole program of the tuberculosis movement, as much as some people think it is; that some people think it is the whole program but it is nothing like that; that it is the house key that unlocks the room and opens up to plain view some of the very hazy things in proper tuberculosis work; it is the charmed word that brings one face to face with things that one wants to see; citing a case where he was called in consultation in the case of a girl who had to work for a living and whom the doctor had ordered to go to Arizona, as there was no other place proper for her to go; that the ordinary layman would know better; some of our doctors don't; this particular doctor's conception of tuberculosis was about as erroneous as any thing he knew of. What is a sanatorium? It is one link in the chain of agencies trying to bring back into normal life the person who has been exposed to tuberculosis; if you prefer it in another way it is one brick in the arch to be built up. Dr. Shields elaborated on his conception of the "Utopian Sanatorium" and the wonderful fascination in sanatorium work; that the illustration he always had had in mind of a sanatorium was of a school or college or university; perhaps it is a school which included in it every class from kindergarten to post-graduate course. The sanatorium should teach, it should train and it should treat, that these three factors should be properly balanced; that the patient should be taught and trained to play the game and how to go out and do the same for others; that many patients who have passed through the efficient regime of a sanatorium know a good deal more about the tuberculosis problem than many doctors; that patients should be trained to do for themselves and not to become parasites; that he heard young Dr. Trudeau say in 1918 that a patient that graduates from our sanatorium and goes out knows more than the practicing physician. Dr. Shields dwelt upon the importance of healthful and economic occupation of the convalescent patients; that if there be no hobby one should be created and the hobby followed so that when the patient is ready to go out something for the future has been accomplished in the acquirement or betterment of the patients equipment to make his way in the world.

Dr. Shields was of uncommon interest and full of instruction and a great inspiration to the gathering.

Among those present were Dr. Dean Abell, president of the County Tuberculosis Association; Freeholder Charles A. Baker; Supt. and Mrs. Roy Bailey of the County Home for Children; Rev. E. A. McAlpin of Madison; Miss A. Leslie Hill, general secretary of the committee for institutional development; Miss Edith L. Smith, county librarian; Miss Helen T. Headley; Mrs. Charles Gay Davis, president of the County Board of Women's Organizations and manager of the County Tuberculosis Association; Mr. Eastman, executive secretary of the State Tuberculosis Association; Superintendent Dufford of the County Home. Considering the state of the weather the number of guests were pleasing and all

indications were that an awakened interest in the sanatorium and its power for good was being better realized.

Reports of Other Organizations

Atlantic City Hospital Staff.

D. W. Scanlan, M.D., Reporter.

The Atlantic City Hospital Staff held its regular monthly meeting at the hospital, Friday evening, June 20th.

Dr. Norman J. Quinn reported a case of ruptured uterus, during labor, which had been previously Caesarian sectioned. The diagnosis was made preceeding operation and the patient experienced an uneventfull recovery. Dr. Barbash reported his medical service, discussing the unusual and interesting cases and the deaths and autopsy of the service. He also read a paper on pericarditis. Dr. Theodore Senseman, the surgical director, reported three cases. The first case was death from cerebral embolism, following cholecystectomy. The second case, a gun shot wound made by a rifle, complicated the erysipelas, which mygrated over the entire body and resulted in death.

The third case reported by Dr. Senseman, is interesting and instructive to those who are acquainted with Hunter of Baltimore and his work in ureteral stricture. This patient, a middle aged adult male, had been under the observation of Dr. D. W. Scanlon for one year for chronic appendicitis. During this time the symptoms referred only to the gastro-intestinal tract. At the end of the year, the patient came to the office and showed symptoms of an acute appendicitis and was sent to the hospital for a stat. operation. When the surgeon then on duty, Dr. David Allman, saw the patient at the hospital, he found the symptoms had disappeared and were replaced by symptoms referable to the right kidney and ureter. The patient was then examined and cystoscoped by Dr. C. H. Shivers, who found an obstruction or stricture of the right ureter and hydronephrophosis. his condition was relived by a ureteral catheterization. The patient stayed well for a wear with the exception of a few recurrent attacks with symptoms reerrable to the G. U. tract, relief of which was given by catheterization.

During this time Dr. Wm. Westcott showed by his radiography, chronic appendicitis with adhesions immediately over the ureter. One year after his first admission to the hospital, as described above, he was admitted one night, in a hurry, for an acute right illiac fossa surgical condition. Dr. Theodore Senseman operated upon the patient and found a ruptured gangerous appendix bound down by a mass of adhesions directly over the right ureter. The patient is still in the hospital recovering from operation.

New Jersey Sanitary Association.

Charles J. Merrill, Health Director, Reporter.

The June meeting of the Executive Committee of the New Jersey Sanitary Association was held at the home of Dr. B. S. Pollak, Director of the Hudson County Tuberculosis Sanatorium at Secaucus, N. J., on June 23, 1924. After enjoying a bounteous luncheon

the members of the committee extended a hearty vote of thanks to Dr. and Mrs. Pollak for their hospitality, following which the business meeting of the committee was held. Dr. Pollak, as chairman of the committee, presided.

It was decided to hold the next annual meeting of the Association in Atlantic City, on the first Friday and Saturday in December, the hotel in which the meeting will take place to be selected later by the special committee. It was voted to extend an invitation to the Health Officers' Association of New Jersey, the Essex County Health Officers' Association, the Associated Executives of the Mosquito Commission and the County Mosquito Extermination Commissions of the State with the Sanitary Association at its next annual meeting.

It was decided to accept a proposition submitted to the committee for the printing of a special program and souvenir for each of the meetings of the Association for the next three years, it being understood that a special edition will be printed of the Fiftieth Anniversary Program for this year. A committee of five members was appointed by the president to adjudicate the matter.

In response to a letter from the Editorial Department of the American Public Health Association, Mr. Charles J. Merrill, chairman of the Publication Committee, was appointed as correspondent to represent the Sanitary Association and to furnish the American Public Health Association with items to be printed in the space to be devoted to this purpose in the Journal of the said Association for matters of interest from affiliated societies.

A number of suggestions offered by members for papers to be read at the next annual meeting, about twelve, together with names of persons who might be asked to read the same, were referred to the president, the secretary and the chairman of the Publication committee, from which to prepare a program for the next meeting.

The secretary of the Association was instructed to communicate with the President of the United States, urging him to name Congressman T. Frank Appleby, President of the New Jersey Sanitary Association, as a member of the International Committee to take up the question of pollution of the ocean outside of the three-mile limit.

The report of the treasurer showing present financial conditions was accepted, and it was decided that a change be made in the constitution of the Association to provide for life membership, the secretary being instructed to send out notice in reference to this matter prior to the next annual meeting of the Association.

One of the recent graduates from the Intern Staff at the Jersey City Hospital, opening a brand new office, waited several days without a visitor. We withhold the Doctors name thru kindness. At last a breathless man came running up the stoop.

"Sit down," said the young doctor soothingly, "what can I do for you?"

"Please allow me to use your phone," gasped the visitor. "My wife is very ill and I want to ring up my doctor."—Hud. Soc. Bul.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

1 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

HAS. D. BENNETT, M. D., Chm., 750 Broad Street, Newark.

EDITOR:

DAVID C. ENGLISH, M.D.,
P. O. Box 83, New Brunswick

ASSOCIATE EDITORS:

CHRISTOPHER C. BELING, M.D., Newark
HENRY B. COSTILL, M.D., Trenton
JAMES HUNTER, JR., M.D., Westville
HARRISON S. MARTLAND, M.D., Newark
FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

DR. MERCER RESIGNS.

As the Journal was about ready for the press, a communication was received from Dr. Mercer, resigning the Presidency. A meeting of the Trustees was held July 2, when the Board accepted, regretfully, the resignation. Dr. Lucius P. Donohoe of Bayonne, the First Vice-President of the Society, becomes Acting President for this year. Report of Trustees' meeting will be given in next month's Journal.

NOT THE EDITOR'S FAULT.

We said in our last month's Journal that we would insert certain Original Articles in the July Journal, but we could not do so.

Author's should not fail to remember and observe our By-law requirements in Section 5, Chapter III., which says: "All papers and reports presented to the Society shall be its property and any author failing to deposit the same with his name with the recording secretary when read, may be debarred from having his paper published in the Journal of the Medical

Society of New Jersey. Permission to publish the same in Medical Journals may be granted by the Committee on Publication."

INDEMNITY INSURANCE.

The Medical Society of New Jersey would like to have 1,000 more of its members insured in the U. S. Fidelity and Guarantee Company of Baltimore, Maryland. The Society has a contract with that Company which offers our members Indemnity Insurance at reasonable rates. There is no safer or better Company. Read Dr. Beling's editorial in the June Journal. Louis O. Faullhaber is the General Agent, 9 Clinton Street, Newark.

OUR ANNUAL MEETING.

As we predicted in our June issue of the Journal would be the case, this year's Annual Meeting of our State Society was the largest meeting we ever held, there being 827 registered as in attendance; although we regret to say that two County Societies had no delegates present. This possibly was due to the fact that the delegates have been usually elected at the annual meeting of the county society, which is held several months before the date of our annual meeting. We believe it would be better to change the time of their selection to the meeting of the county society held just before our annual meeting.

Our Annual Meeting was not only the largest, but also one of the best ever held. Larger numbers of delegates attended the sessions of the House of Delegates and most of the business was transacted with careful deliberation and dispatch. The Standing and Special Committees presented excellent reports, which showed a year of good work done and wise recommendations were also advised therein; the scientific papers presented; the orations in Medicine and Surgery by Drs. Beardsley and Bloodgood, respectively, were of a high order of excellence and practicability as was the address of Lawyer Whiteside on "Enforcing the Medical Practice Act," and also the address of President Eagleton.

A. M. A. ANNUAL MEETING.

When the American Medical Association met in Chicago in 1908, the total registration was 6,446, a record unequalled until the present session, at which 7,819 registered. For this magnificent registration, credit must be given first to the local committee, which secured a high percentage of

attendance of physicians in Chicago, and secondly to the great interest aroused by the numerous special features included in the 1924 session. The experiment with the municipal pier, which involved making over the second tier into exhibits halls and meeting places for the sections, was quite successful. Minor difficulties in the way of ventilation and the transmission of sound interfered in some instances with the larger halls, but the general satisfaction resultant on the ease of access to the exhibits and the ability to go rapidly from one meeting place to another outweighed such defects. The Scientific Exhibit far surpassed any previous one conducted by the Association. Several special exhibits were the means of conveying to those interested the latest advances in the fields of pathology and in the prevention and relief of heart disease. Commercial exhibitors were more than satisfied because of the large attendance and because the arrangements were such as to permit Fellows to pass through the exhibit on their way to attend the meetings in the Scientific Assembly. The meetings of the scientific sections were attended by large numbers at all sessions. Some of the halls provided seats for as many as 1,200 physicians, and yet were crowded to capacity.—*Editorial, A. M. A. Jour.*

At the meeting of the House of Delegates held June 11th, Dr. Wells P. Eagleton presented the following resolution adopted by our State Society:

Resolved, That the delegates of the Medical Society of the State of New Jersey be instructed to use their influence and vote (1) to disassociate the editorship and general management of this Association, on the retirement of Dr. Simmons, placing the editorship entirely separate from the general management of the Association so that the editor may devote his entire time to the scientific and ethical aspects of the profession. And that they use their influence and votes (2) to obtain an ad interim meeting of the House of Delegates at the headquarters of the Association annually, as it is impossible for the House of Delegates to do their full duty by the Association by having a meeting but once a year.

It was referred to the Committee on Miscellaneous Business, which committee subsequently reported as follows:

The committee concurs in the resolution so far as it separates the office of Editor and General Manager on the retirement of Dr. Simmons, subject to the approval of the Board of Trustees. On the matter of obtaining an ad interim meeting of the House of Delegates, your committee feels that this question is covered on page 8, Constitution and By-Laws, Section 2, which says:

SPECIAL SESSIONS.—Special sessions of the House of Delegates shall be called by the Speaker, on written request of twenty-five or more delegates representing one third or more of the constituent associations; or on request of a majority of the Board of Trustees.

Since the ad interim meeting question covered as stated above, your committee does not concur in this part of the resolution. This was adopted.

ORIGINAL PETITION OF OUR SOCIETY FOR EXTENSION OF CHARTER IN 1815.

Dr. H. B. Costill presented to our Board of Trustees the original copy of this application of our Society, in writing with the signatures of the committee that applied to the Legislature for the extension of charter. It is as follows:
Petition of the Medical Society of New Jersey for Extension of Charter, read January 19, 1815, and com'd to Messrs. Munn, Bayard, Ellis, 1815.

To the Honorable the Legislature of the State of New Jersey.

Petition of the Medical Society of New Jersey.

Your petitioners beg leave to represent to your honorable body that the "Act passed June 2d, 1790, for incorporating certain number of Physicians and Surgeons of this State by Style and Title of the Medical Society of New Jersey" will expire at the end of the first sitting of the next Legislature, and that your petitioners are appointed and duly authorized by said Medical Society to pray your honorable body to grant a renewal of its Charter under such modifications and restrictions as in the wisdom of the Legislature shall be deemed expedient. The public utility and importance of well regulated medical institutions have been universally acknowledged from time immemorial. Every European government has for ages cherished with peculiar care and interest all attempts to improve the healing art. Their celebrated schools and associations instituted for the improvement of the various departments of medical and surgical science, bear ample testimony of this fact.

Your petitioners need scarcely mention to this enlightened Legislature the incalculable advantage and benefit which Europe, this country and the world have received from the learned and well regulated medical institutions of Paris, Edinburgh, London, Vienna, Geneva and many others on the European Continent. And in our own country, several of the States of our Union have been exceeded by none in acts of liberality and encouragement towards the promotion of true science, and the extension of useful medical information. An

our petitioners are proud to say that the wise and liberal Legislature of this State has among the first to step forward and extend its fostering care and protection to the learned professions, particularly to that profession to which we are members, and for whose interest, responsibility and usefulness we feel ourselves responsible, since by your acts we have been made its guardians.

Your petitioners have and will make it their constant endeavor to discourage and check imposture and quackery which are nearly destroying many of your valuable and useful citizens; they will use all lawful means to admit none to practice but such as shall be well qualified by that previous study, learning and practical experience which will effectually guard the citizens of this State, who are under your special care and protection, from that fraud and ignorance to which they have long been exposed, and as in duty bound your petitioners will ever pray.

Committee,

N. Belleville, Enh. Wilson, John Vancleve.

MEDICAL SOCIETY OF NEW JERSEY.

New Members Since Last Report.

Abrams, A. B., 668 Clinton av., Newark.
 Balson, Zachary D. B., 241 16th av., Newark.
 Barrett, Arthur F., 460 Fairmount av., Newark.
 Burke, Stephen E., 212 First av., Newark.
 Bowen, Horace, 2801 Boulevard, Jersey City.
 Connolly, Thomas W., 921 Bergen av., J. City.
 Dexter, Harriet E. T., 903 Ave. C., Bayonne.
 Dilger, F. G., 367 Commercial av., Cliffside Park.
 Filkins, Cedric E., Oaklyn, N. J.
 Froomes, Leo E., 39 Lincoln Park, Newark.
 Gnasso, E. R., 474 No. 13th st., Newark.
 Klein, Ignatz, 471 Springfield av., Newark.
 Linden, M. H., 45 Clendenning av., Jer. City.
 Murphy, Leo J., 374 West st., West Hoboken.
 Peters, E. A. P., 277 Bergen av., Jersey City.
 Roth, Samuel R., 100 Spruce st., Newark.
 Robinson, Loyis H., 511 Clinton av., Newark.
 Sehunmacher, F. R., 161 Kearney av., Kearney.
 Smith, J. Stuckey, 765 Ave. C., Bayonne.
 Spiegel, August, 1808 Bloomfield av., Hoboken.
 Wegeman, Max, 200 Ferry st., Newark.
 Willner, Irving, 18 Waverly av., Newark.
 Wiren, William E., 189 Ave. C., Bayonne.
 Byington, R., Summit.
 Cecide, Joseph, 264 Lafayette st., Newark.
 Dodd, Raymond C., 16 Snowden pl., Glen Ridge.
 McArthur, Charles, 5 Elm court, So. Orange.

Reinstated Members.

Burnett, Thomas T., 151 Court st., Elizabeth.
 Hitchcock, Wm. E., 55 1/2 Belleville av., Newark.
 King, George W., Laurel Hill.
 Tirico, Antonio B., 9 Clover Hill pl., Mtclair.

MEDICAL SOCIETY OF NEW JERSEY.

Officers elected at the Annual Meeting.

President, Archibald Mercer, Newark.
 First Vice-President, Lucius F. Donohue, Bayonne.

Second Vice-President, Walt. P. Conaway, Atlantic City.
 Corresponding Secretary, W. J. Carrington, Atlantic City.
 Recording Secretary, J. Bennett Morrison, Newark.
 Treasurer, Elias J. Marsh, Paterson.
 Trustees, O. H. Sproul, Chairman, Flemington;
 D. C. English, Secretary, New Brunswick.
 Councillor, 5th District, Walter P. Glendon, Bridgeton, in place of Dr. Conaway, elected Vice-President.

The full list of officers and committees will appear in our August Journal.

COMMITTEES APPOINTED SINCE THE ANNUAL MEETING.

By President Mercer, in Consultation with Vice-Pres. Donohue and Sec'y Morrison

Committee on Honorary Membership.

WALTER B. JOHNSON, Chm.....Paterson
 GEORGE H. SEXSMITH.....Bayonne
 THOMAS W. HARVEY.....Orange

Committee Appointed to Co-operate with Psychopathic Clinics and Children's Courts.

DAVID F. WEEKS.....Skillman
 FREDERICK C. HORSFORD.....Newark

Committee on Health Problems in Education.

GEORGE J. HOLMES, Chm.....Newark
 CLARA K. BARTLETT.....Atlantic City
 RUFUS B. SCARLETT.....Trenton
 OLIVER C. McDONALD.....Trenton
 JULIA C. MUTCHLER.....Dover
 MARGARET N. SULLIVAN.....Jersey City

Committee on Standardization of Hospitals.

JOHN C. MCCOY, Chm.....Paterson
 DAVID A. KRAKER.....Newark
 GEORGE N. J. SOMMER.....Trenton
 HOWARD S. FORMAN.....Jersey City
 WILLIAM E. DARNALL.....Atlantic City

Committee on Business.

JOHN F. HAGERTY.....Newark
 DAVID F. WEEKS.....Atlantic City
 W. BLAIR STEWART.....Atlantic City
 EMANUEL D. NEWMAN.....Newark
 GEORGE H. MCFADDEN.....Hackensack

Committee on Standardization of Disability Estimates in Traumatic and Occupational Diseases.

JOHN F. HAGERTY.....Newark
 PAUL M. MCCRAY.....Camden
 EPHRAIM MULFORD.....Burlington
 IRVING M. VANDERHOFF.....Newark

Committee on the Standardization of the Degree of Disability in Industrial Eye Injuries.

ELBERT S. SHERMAN, Chm.....Newark
 WILLIAM D. OLMSTEAD.....Trenton
 CHARLES S. SCHLICHTER.....Elizabeth
 WILLIAM N. GOODWIN.....Newark
 ELIAS J. MARSH.....Paterson
 ALFRED CRAMER, JR.....Camden

Committee on Welfare.

JAMES HUNTER, JR.....Westvill
 THOMAS W. HARVEY.....Orange
 HENRY B. COSTILL.....Trenton
 ANDREW F. MCBRIDE.....Paterson
 JOHN C. MCCOY.....Paterson
 GEORGE T. BANKER.....Elizabeth
 WELLS P. EAGLETON.....Newark
 FREDERICK J. QUIGLEY.....Jersey City
 G. VAN VORIS WARNER.....Red Bank
 DAVID C. ENGLISH.....New Brunswick
 STEPHEN QUINN.....Elizabeth
 GEORGE H. LATHROPE.....Morristown
 ARTHUR L. SMITH.....New Brunswick
 W. BLAIR STEWART.....Atlantic City
 ELBERT S. SHERMAN.....Newark
 WILLIAM G. SCHAUFFLER.....Princeton
 A. HAINES LIPPINCOTT.....Camden
 RICHARD M. H. DAVIS.....Salem
 LANCELOT ELY.....Somerville
 JOSEPH H. MORROW.....Oradell
 J. BENNETT MORRISON.....Newark
 ARTHUR W. BELTING.....Trenton
 CHARLES J. LARKEY.....Bayonne

WELFARE COMMITTEE'S MEETING.

Joseph S. Gunn, Secretary.

The Welfare Committee of the Medical Society of New Jersey held a meeting at the Essex Club, Newark, on June 1, 1924. Dr. W. P. Eagleton announced that the meeting had been called to transact business that should have the action of the Welfare Committee before the annual meeting. He also announced that the Welfare Committee had submitted to Governor Silzer two sets, of three names each, for appointments, to membership on the State Medical Board. From one set Dr. Henry B. Diverty of Woodbury, was selected to fill the vacancy caused by the death of Dr. George Reading of Woodbury, and from the other set Dr. Charles B. Kelley of Jersey City, was selected to fill the vacancy caused by the death of Dr. John J. Mooney, Jersey City.

On suggestion it was decided to recommend to the incoming Welfare Committee that some of its meetings be held in South Jersey in order that it be made convenient for the committee members from South Jersey to attend the meetings.

Dr. Eagleton read a communication from Mr. Whiteside, special counsel to the Welfare Committee on proposed legislation, suggesting a number of changes in the Medical Practice Act. On motion by Dr. Quigley, it was declared to be the sense of the meeting that Mr. Whiteside be instructed to proceed with the preparation of a bill or bills to provide for the proposed legislation.

It was announced by Dr. Eagleton that he had written to the State Medical Board, inquiring if the Mecca School, located at Newark, had been checked up to ascertain if it conforms to the provisions of the new State Law requirements for schools of healing, and and if it does not for the Medical Board to proceed against the school in accordance with the provisions of the new law.

On motion by Dr. Quigley, the bill of Mr. Stryker for legal services in connection with the drafting of bills, giving opinions, etc., amounting to \$600 was ordered paid. On motion by Dr. Donohue, the bills of Joseph H. Gunn, for secretarial work, attendance at Legislature, telephone and telegraph charges, printing, bulletins, letters, etc. and postage, amounting to \$1,411.71, were ordered paid. On motion of Dr. Banker the bills of Miss Wolters, Miss Huyler and Miss Toll, for stenographic work were ordered paid. On motion by Dr. Pinneo, the bill of Whiteside, Stryker for \$250 for legal services in drafting medical bills, was ordered paid.

Dr. Eagleton recommended as a program for the coming year, that bills be presented to the Legislature, limiting the use of the title "Doctor" and to make certain changes in the Medical Practice Act, which would make it more effective, and to provide for certain qualifications for those who would practice healing, and which would afford a greater protection to the public. He also recommended that the Committee endorse the Governor's recommendation for a survey of the schools of the State and that the survey include medical phases. On motion the recommendations were approved.

On motion by Dr. Quigley, it was recom-

mended that the State Medical Society employ a full time executive to take charge of the Society's welfare work.

On motion the meeting adjourned.

A Tribute to the Physician.—Behold the unassuming bravery of the physician! He sacrifices rest and comfort. He risks his life. He asks not who the patient is; it is enough that it is a suffering fellow-being. Medical practice brings him a living, but he carries it out as a help to others. He does his utmost in the midst of our peaceful or troubled existence; a quiet heroism is at work to which hardly any one pays any attention. The physician himself sees nothing remarkable at all in his courage or efforts. It is the simplest and most natural thing in the world. Such is the true physician in Christendom.—Nathan Soderblom, Archbishop of Sweden.

Drs. William J. Condon and James I. Schureman, New Brunswick, members of the Medical Officers Reserve Corps, U. S. Army, have been ordered to active duty at the Medical Field Service School, Carlisle Barracks, Pa. on July 7th, they will return home July 21st. Dr. Condon will rank as major and Dr. Schureman as captain.

No Such Thing.—"Has that mule of yours got a pedigree, Sam?"

"No sah! No, indeedy! Dere ain't nuffin de matter wif dis mule. He am puffedt sound, sah."—Boston Transcript.

HEALTH PROBLEMS IN EDUCATION.

Report of Committee at Annual Meeting
Harry W. Haight, M.D., Chairman.

The Committee on Health Problems in Education is a special committee appointed to carry on the work of a committee by the same name which was discontinued last year. Dr. Hunter has expressed the purpose of the committee when he said in addressing a large educational meeting "The Medical Profession of New Jersey wants the New Jersey School Children to Have the Best Chance for Good Health that any School Children Have." The committee is pleased to report progress as follows:

1. A state wide reform in the teaching of hygiene to all pupils in the public schools has been secured. Hereafter the pupils in the public schools must stand a state examination in hygiene just as they do in arithmetic and other fundamental subjects. The State Commissioner of Education has issued a bulletin to that effect. Many public school pupils who did not formerly study hygiene are now studying hygiene. The first State examination will be held this June.

2. Some of the prominent educational experts in the State have been led to see the necessity of having a competent and experienced medical man for the supervision of the school health work.

3. The State Educational authorities were led to see the necessity of including a school health program as one of the two objects of the gigantic educational conclave held in Newark in February, 1922. Representatives of this committee were asked to attend.

4. In a special message to the legislature requesting an appropriation of seventy-five thousand dollars and authority to make a survey of the entire public school system through the medium of a committee of nine members, Governor Silzer mentioned the school health program as among the activities needing survey.

5. The committee has made considerable study of the school health program. It has been discovered that a sort of a bureau of health exists in the State Department of Education; that this department supervises wholly in part seven groups of activities, to wit: Instruction, Physical Education, Habit Hygiene, Nutrition, School Nursing, School Dentistry and Medical Examination. One of the educators speaking at the Newark meeting stated that the activities are not well co-ordinated and declared co-ordination was needed. An opportunity was given for negative discussion. There was no dissenting vote. It is natural for one to wonder how it happens that the school health program is under the control of the State Board of Education and the local Boards of Education rather than the State Board of Health and the local Boards of Health. This appears to be accounted for by the development and evolution of the school health program. The activities enumerated above did not originate and evolve in the State Board of Health and in local Boards of Health. They originated in the schools which the Boards of Education control. The control has remained there because of the sentiment of the school teachers and school supervisors against it so. Efforts to change that sentiment probably would not be successful and might result in so much antagonism that the school health program would fall flat because of necessity the school supervisors and the school teachers must carry on seven-tenths or eight-tenths of the work in person. The school health program has been further located in the State Board of Education by the physical education law which was passed in 1917 and by the medical examination law which was passed in 1909. Another potent factor in the situation is the fact that the State Board of Education apportions something like thirty per cent. of the school moneys. This power of course enables them to have their regulations carried out. The Board of Health has no such power in the schools. That part of the school health work in which the medical profession is most directly concerned; to wit: The work of physical examination is considerably criticised.

6. It has been discovered that the work of physical examination at the Women's College in New Brunswick is highly satisfactory. Here the student comes to the college with a certificate from the family physician which the parent pays for. Not only is the actual holding of the examination made much more certain but the quality, the connection with the family, the follow-up, and the interest in health are all better too. This circumstance is mentioned not necessarily as the remedy for the existing public school system but in justice to the medical profession whose members it has often been said would not be interested in such work and that such an arrangement would not work well at all. As the matter of physical examination in the State now stands there are

seven hundred thousand children to be examined annually. That means three and one-half million dollars worth of physical examinations. The State is attempting to get this work done for six hundred and twenty-five thousand dollars. When one considers that the work of physical examination is only an eighth part of the school health program one may judge of the scope, the magnitude and importance of these activities.

7. As a possible means of adjusting the present State mechanism and as a basis for discussion, two supplements to the two existing laws were prepared by the chairman of this committee and several legal and educational assistants. The first would enable local Boards of Education to secure their physical examinations as they are secured at the Women's College. It would not abolish the present system but would retain it for medical inspection, for supervision and for the poor. The examination would not be at the expense of the taxpayers but at the expense of the parents. The second supplement would broaden the physical training law in such a way that it would be possible to secure an experienced medical man to supervise the school health program. The committee, however, does not believe the time is ripe to attempt legislation.

Recommendations.

1. The committee recommends that a vote of thanks and appreciation be extended to the following individuals for furthering the school health work in the State, and that the secretary notify them to that effect:

Hon. John Enright, Commissioner of Education, Trenton; Mr. Charles J. Straham, Assistant Commissioner of Education, Trenton; Mr. Roy L. Shaffer, Assistant Commissioner of Education, Trenton; Mrs. Edward L. Katzenbach, Member of State Board of Education, Trenton; Senator Morgan F. Larsen, Perth Amboy; Assemblyman Harold G. Hoffman, South Amboy; Assemblyman Thomas L. Hansen, Perth Amboy; Assemblyman Fred W. De Voe, New Brunswick.

2. As a means of throwing additional light on this entire subject the committee recommends the following resolution:

Resolved, that the members of the Medical Society of the State of New Jersey, assembled in annual meeting at Atlantic City, June 5, 1924, highly commend the initiative and insight of Governor Silzer in asking the legislature for an appropriation of seventy-five thousand dollars and authority to name a commission of nine members and to conduct a survey of the public school system. We strongly recommend to the legislature that this action be taken, but with the proviso that one of the nine members be a competent medical man; that the survey of the health program be under his direction and that one-ninth of the funds appropriated be used for this purpose. This committee would further recommend that the Welfare Committee be instructed to use their utmost efforts to affect this object.

3. A second contingency should be provided for. In the event that either house of the legislature is politically opposed to the Governor, the survey probably will not be held. (It may never be held). If this condition obtain we recommend that the Welfare Committee be

instructed to hold a meeting on school health similar to the meeting held on Workman's Compensation, by December 1, and attempt to evolve and promote legislation which will help to remedy the existing situation.

A Portrait of Yourself by a Man Who Is Figuring When You Die.

It is the business of E. E. Rittenhouse of the Equitable Life Assurance Society to figure when you will die.

He keeps an eye on you all the time. Not on you personally, but you as an average American.

And here is his report about you as presented to the life insurance presidents.

You look smooth, pink and healthy.

You are a good liver. (He said are, not have.)

You hurry. The medium age at death of the American people is 43.

Your eyes have been strained by inside work: hence the glasses.

You are seriously overstraining heart, arteries, kidney, nerve and digestion—as the rapidly increasing death rate shows.

You could detect and head off these troubles if you would go to a doctor for an occasional examination.

Under exertion you are short-winded, due to lack of exercise or a bad heart.

Your four hundred muscles are virtually all soft and weak from lack of use.

You are designed as an erect, outdoor animal, with feet and leg service; but you lie down all night and sit up all day.

You never walk when you can ride.

Thearches of your feet are gradually falling, because the muscles provided to hold them up have weakened from long disuse.

Your ancestors lived on a farm; the proportion of people living in cities have increased 131 per cent. in fifty years.

You feed your stomach with all sorts of "tasty junk," much of which cannot be fully digested; so you develop anti-intoxication.

With every pound of fat you gain your chances of a shortened life increase.

You eat 30 per cent. more food than your grandfather did; and 374 per cent. more sugar.

You spend 367 per cent. more for patent medicines and drugs than your father did; and drink 54 per cent. more coffee.

In your easy-going optimistic way, you are cheered by the fact that the general death rate is declining. Your fool yourself with the notion that this means a green old age for you.

As a matter of fact, the decrease in the death rate is due to the better care of infants.

Not only is the adult death rate decreasing; it is alarmingly increasing.

Since 1900 the death rate from Bright's disease has increased 15 per cent.; from disease of the heart, 27 per cent.

These are the diseases of the adult life—the diseases of hurry and worry and overeating and nervous wear and tear.

This is not our picture, remember. It is painted by Mr. Rittenhouse, whose business it is to figure how much you ought to pay for life insurance, in view of the fact that you

will probably die before you are fifty years old.

Mr. Rittenhouse says there is hope for you. An annual medical examination; more exercise outdoors; less food; more dentistry; no booze; more walking and less taxicabs.

Most of all—no hurry and no worry.

Simple rules—sensible—guaranteed to put you across the fifty mark, with a good chance for sixty and maybe seventy-five.

But Mr. Rittenhouse isn't very hopeful that you will adopt them. He has been watching you quit a long while—

Sitting up in his office: figuring away, figuring about when you will die.—N. B. V. Jour.

Deaths from Diphtheria in Family of Chiropractor.

To the Editor:—We have recently had occurrence in this city which deserves some mention. We have here a chiropractor who has persistently advertised in our daily paper and flaunted in the faces of the public that he has been here for upward of twelve years. Chiropractors are not recognized by the law of Missouri, and in certain towns they are arrested and fined for practicing medicine without a license; but in this community it is said to be practically impossible to obtain a conviction. A list of convictions of chiropractors in St. Louis has been given to the prosecuting attorney, and it is understood that he has presented the matter to the grand jury, but so far no action has been taken.

About three weeks ago the wife of this chiropractor became ill with diphtheria. It is said that she begged for a physician, but her husband gave her "adjustments" and assured her that she was getting better. When she was practically moribund, her son, it is said, called in two physicians, who gave her antitoxin although they pointed out that it was too late for it to do any good. The children were also called into the room on the day that the mother died. A few days after, the son became ill with diphtheria. The father called in two consultants, both chiropractors, one from St. Louis and one from Kansas City, and "adjustments" were again done. When this boy was in dying condition, one of the regular physicians who was called for the mother was asked to see him. He again, in the presence of the three chiropractors, told them that it was too late to do anything, but that he felt it his duty to give antitoxin, as it offered the only possible hope. The boy also died. It is probably needless to add that the antitoxin is charged with having been the cause of death in both cases. One can sympathize with the physicians who were called in; while some of us might have been tempted to refuse to give antitoxin when it seemed evident in both cases that the patients were dying, the honest physician acts on the principle that while there is life there is hope, and tries to save life even though it may appear impossible to do so.

It is perhaps unusual for cases like this to occur in families of chiropractors, where the sufferers could obtain at the earliest moment and without cost the wonderful advantages of spinal adjustments. The question is, "Will it teach the people who patronize these cults a lesson?"—Mazyck P. Ravenel, M. D., Columbia, Mo., from J. A. M. A.

Hospitals; Sanatorium, Etc.

Ann May Hospital Training School, Spring Lake.—Six nurses graduated from this school June 11th.

Englewood Hospital School of Nurses.—Twenty-five nurses were graduated from this school last month. Dr. Alfred W. Ward, president of the medical board, presented the diplomas.

Somerset Hospital, Sommerville.—This hospital training school graduated seven nurses June 12th.

New Jersey State Hospital, Morris Plains.—The 48th annual report of this hospital for year ending June 30th, 1923, shows: In hospital July 1, 1922, 3,611; admissions during the year, 527, of whom 274 were males and 253 females; 62 were diagnosed as senile psychosis; 4 as psychosis with cerebral arteriosclerosis; 10 general paralysis; 104 manic depressive psychosis; 135 dementia praecox. There were discharged 184; as recovered 65; improved, 98; unimproved 17; and 4 as not insane. There were 271 deaths; the chief physical causes of deaths were pulmonary tuberculosis, 27 cases; cerebral hemorrhage, 36; disease of circulatory system, 62; pneumonia, 18; nephritis, 34.

Bonnie Burn Sanatorium.—Dr. J. E. Runells, superintendent, reports that on April 6th there were 261 patients in the sanatorium, 148 males and 113 females. This included 80 children in the preventorium. Since the last report 27 patients have been admitted, 7 males and 10 females. Eleven of these admissions went to the preventorium. The admissions are classified as follows: Pretubercular, 10; moderately advanced, 5; bone tuberculosis, 1; far advanced, 11. The largest number of patients present at any one time during the month has been 265, smallest number, 256. Present May 28th, 265. This number includes 87 children in the preventorium and 86 out of the county patients.

MEDICAL EXAMINING BOARD'S REPORT.

	Exam.	Passed	Failed
Alabama, Jan.....	8	7	1
Colorado, Jan.....	5	3	2
Dist. Col., Jan.....	9	7	2
Kansas, Feb.....	8	8	0
Oklahoma, Jan.....	1	1	0
Oregon, Jan.....	14	12	2
Vermont, Feb.....	4	4	0
West Virg., Jan.....	10	9	1

Marriage.

DWYER-DUNN.—At Paterson, N. J., June 5, 1924, Dr. William A. Dwyer to Miss Amelia M. Dunn, both of Paterson.

Deaths.

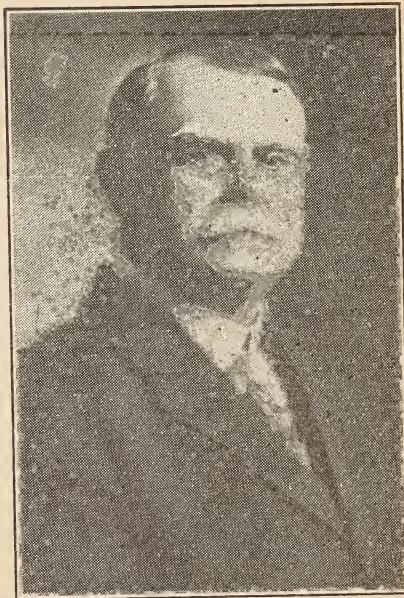
GRIM.—At St. Francis Hospital, Trenton, on May 21, 1924, Dr. Frank S. Grim of French-

town, N. J. He graduated from Jefferson Medical College, Philadelphia, in 1895. He was mayor of Frenchtown.

SHIPPS.—At Bordentown, N. J., June 1, 1924, Dr. William H. Shipps, aged 74 years. Dr. Shipps graduated from the University of Pennsylvania in 1878.

HUSTED.—At Woodstown, Salem County, April 29th, Dr. Joseph M. Husted, aged 50 years. He graduated from the University of Maryland in 1897. He was a member of the Salem County Medical Society, State Society, the A. M. A., and on the surgical staff of the Salem County Memorial Hospital. Acute dilation of the heart caused his death.

IN MEMORIAM.



GEORGE EVANS READING, M.D.,
Woodbury, N. J.

The following memoir of the late Dr. George Evans Reading, of this city, was presented by Dr. James Hunter of Westville, and adopted by the Gloucester County Medical Society at their meeting on Thursday, March 20, 1924.

Dr. George Evans Reading

The Gloucester County Medical Society meets today without our faithful Secretary and Treasurer, Dr. George Evans Reading. With one exception, due to illness, it is the first time since I have been a member of this society, some thirty years or more, that this has happened.

Always punctual, ever alert and ready for business, you were never for a moment in doubt that the society was in session with the secretary present. He liked promptness and dispatch in all proceedings, and if the president was absent or late in arriving he would suggest that some one be elected pro tem, and we would get quickly under way with the day's program. His was the dominating personality. He was an official in every organization of which he was a member, and you were never

at a loss to know where he stood upon various questions involving the interests of any of them.

In the history of the Gloucester County Medical Society during the last three or four decades, two names stand out conspicuously as we recall those who worked for the interests of the society, namely, the late Drs. Reading and Halsey.

This society has had a long and honorable career. One hundred and sixteen years ago we came into existence. We grew and waxed strong with the years as they passed. Our roster contained the names of those prominent in the medical annals of the State and county. Among these were the names of some of the charter members of the Medical Society of New Jersey.

Like all human organizations, our society had its periods of prosperity alternating with those of depression. During one of the latter periods, 1890-91 the society became almost moribund. Meeting in the course of their professional work Drs. Reading and Halsey discussed the deplorable lack of interest in the current work of the society, and agreed upon a policy which had for its object the reorganization of the society, and the instilling of renewed life and activity into the meetings.

Dr. Halsey issued an invitation to all the medical men of the county to meet as his guests at Williamstown, N. J. Prof. James Tyson, of the University of Pennsylvania, was the guest of honor, and read a most able paper upon "Progressive Pernicious Anemia." This paper was discussed by those present, following which they were entertained at dinner by Dr. Halsey.

During the dinner Dr. Reading was asked by Dr. Halsey to say a few words in behalf of their plans for a re-organization of the county society. Dr. Reading then made an aggressive, earnest plea for greater interest in the welfare of the old Gloucester County Society. So effective was this appeal, that the society reorganized, took on a new lease of life, elected Dr. Reading as secretary-treasurer, and has continued to function actively until the present time.

The success or failure of our county societies depends upon the efficiency with which its elected officers function.

Of all elected officers, by all odds the secretary-treasurer is the most important to the success and activities of any County Medical Society. Dr. Reading brought to the office a remarkable ability for the duties of secretary. His energetic, alert and diligent efforts for the good of the society always produced results.

His perspicacity, or the power to see clearly through that which is involved or difficult was most striking, and served us well in many a tight place in our history. He had faith in himself. He believed very positively in himself, his opinions, his methods and mission in life. He was a living proof of the old saying "Believe in Yourself, if You would Have Others Believe in You." His language, at times more graphic than elegant, was marked by a lucidity of expression that left no doubt as to just what he meant.

I recall a tale of a patient that consulted him concerning an advanced case of Bright's disease. Reading ordered him to bed at once, and upon the patient remonstrating that he

could not do so on account of his financial condition, Dr. Reading replied: "Very well! You can take your choice, either go to bed or go hell, suit yourself!" The patient, one of the stubborn type, was duly impressed, however, and went to bed as directed, prolonging his days by so doing. Dr. Reading would never tolerate disobedience in a patient under his care.

The society was fortunate in being able to retain this very able secretary-treasurer in office continuously for over thirty-five years thereby avoiding the handicap of breaking new men to the exacting and at times onerous duties of the office.

As a physician, he was popular with a large clientele, whom he served loyally and faithfully. He was well read in medical lore, a careful diagnostician. Never afraid to admit he did not know if such was the case. He was a good consultant. A man with many resources as to treatment. He was no therapeutic nihilist, but had an abiding faith in the materia medica, especially as laid down in the writings and teachings of his old time teacher and friend, Prof. Bartholow of Jefferson College. He once told me that the most valuable work in all his large medical library was Bartholow's Therapeutics. He was a born politician, in both medical and civil life. Dominant and aggressive in action and expression. At times a little too assertive for the good of his political aspirations. His activities were many, and oftentimes widely divergent, but his knowledge of men and affairs, the assiduity and industry he brought to bear upon all he undertook brought to him success never attained by the timid or faint hearted.

He was one hundred per cent. American and proud of it. His forbears were of early Colonial stock. Colonel John Reading, founder of the name in America, came from England prior to 1684, and settled in what is now Gloucester County. Then followed such proud names as Governor John Reading, 1747—the first native New Jerseyman to govern the Province.

He served again in 1757-59. His grandson Captain John Reading, fought in the struggle for independence 1776-1780. Then followed his grandfather, Joseph Reading, his son Philip Grandin Reading, the father of our Dr. George Evans Reading. With such a noble heritage it is no wonder that there was developed the type of man it has been the good fortune of this society to possess as its secretary-treasurer.

Always the center of our activities as a society, the point of contact of all its interests, the human dynamo supplying the initiative and energy that has kept us together and active in all our goings and comings. Appreciating his faithfulness and loyalty to the society and its interests, we can say these things not that he has left us, with the full realization of all that he meant to us.

Some of us had planned to have made some formal acknowledgement of his long service to us at the next annual social session of the society, but death, never considerate, has anticipated our intentions, and this meagre tribute to his worth is our offering in lieu thereof.

An old Latin proverb tells us "They are able because they think they are so," this thought was the dominating motivation of Dr. Reading.

g's life. He had faith in himself and his mission in life, even "unto the end!"

He has left us for "that bourne from which no traveler returns."

There the work of life is tried by a juster judge than here."

And only the Master shall praise us, only the Master shall blame;

and no one shall work for money, and no one shall work for fame;

but each for the joy of working, and each in his separate star

shall draw the thing as he sees it for the God of Things as They Are."

Public Health Items.

Among the papers in the office of the Division of Vital Statistics of a Western State there has recently been found the following note:

The following causes of death have appeared on death certificates in former years: "Paralyses of the hart," "Celery morbis," "Nateral causes," "Tired of living (99)," "Erley rising and marriage," "Suicide—self-inflicted," "Why nobody knows." "A decedent named Anna Kidney died of hart failure s certified by two nabors," "Amediate caus f deth sleeping paresis," "Worried to death y troublesome neighbors," "Serving God and iving with her husband and children," "Taking Dr. Bostwick's medicine."

Newark Health Report.—The Health Department reports for April 499 deaths, or a death rate of 12 per 1000 population. The principle causes of death were: Diphtheria, 9; tuberculosis, 33; cancer, 33; apoplexy, 39; organic heart disease, 66; pneumonia, 53; Bright's disease, 43 cases. There were 909 births.

New Jersey's Death Rate.—The death rate in New Jersey for April was 13.06, as compared with 13.53 for the preceding month, according to the report made by the Bureau of Vital Statistics. There were 3,798 deaths reported during April, including 512 of children under one year of age, 201 of children more than one year and under five years and 1,485 of persons sixty years or older.

Medical School Inspection.—Medical inspection receives the same care in the poorer districts that is given in the wealthier districts in Pennsylvania. Dr. C. H. Miner, secretary of health, says that is the only state conducting a state-wide school inspection under direct supervision of the state health department. He says that as a result of the system in first-class school districts 40.1 per cent. of all physical defects in school children are corrected as a result of inspection; 53 per cent. of those in second-class districts and 29.5 per cent. in fourth-class districts.

Decreased Infant Deaths.—As a result of effective child hygiene work, deaths of infants between the ages of one month and one year have been so much decreased that the deaths under one month represent one-half of the total deaths under one year. This declaration

was made by Dr. Julius Levy, consultant of the Bureau of Child Hygiene, in an address at the annual conference of teachers of child hygiene at the state house, Trenton, on June 12.

Virulence of Germs in Corpses.—Dr. G. Florito, in *Riforma Medica*, Naples, cultivated colon and proteus bacilli from a corpse exhumed two months after death. The germs were more virulent in experiment on guinea-pigs than similar germs obtained from living persons.

Deaths in England and Wales.—Deaths from influenza in England and Wales for the first quarter of this year numbered 12,604, according to official statistics. The total deaths from all causes for the quarter were 160,279, being 35,559 in excess of the total for the corresponding period last year.

Don't Worry If You Can't Sleep Nights.

To make a business of sleep is a bad habit. That is what persons do who worry because they can't sleep.

In answering a question about insomnia, *Hygeia*, the popular health magazine, in its April issue declares that the chief harmful effects from not sleeping are caused not by sleeplessness, but by worry over not sleeping.

Sleep should and will come naturally, if one will only realize that it is rest and not sleep that is needed, says the health journal. Of course it is important to pay attention to the ordinary rules of hygiene, with regard to exercise, fresh air and reasonable diet. But, above all, it is important to fill one's life with satisfactory work and play. The best incentive to sleep is still the feeling of "something attempted, something done," particularly something to help others.

As to the amount of sleep needed by different persons, that varies within wide limits and is much modified by habit. Many energetic, active individuals get along quite well with four or five hours of sleep. The proper amount for the average adult, however, is usually between seven and eight hours.

Rehabilitation.—Minnesota Medicine says: Physicians especially are in a position to appreciate the need of assistance to individuals who are incapacitated from continuing their previous vocations on account of disease or accident. No one who has not become thus disabled can appreciate the agony of spirit experienced by one who is forced by circumstances to look forward to a future of financial helplessness and dependence. The physician more than anyone else is in a position to assist such individuals by putting them in touch with this newly established Division of Rehabilitation, which will help them to help themselves.

Duringer, the Wonderful Discoverer!!—Ninety per cent. of the consumptive and cancer cases are due to vaccination and the use of iodine, Heinrich Duringer of New York, told the Eastern Chiropractors' Convention at the Ambassador. Vaccination and iodine destroys tissue, with the further result that everything around the tissue decays, finally resulting in consumption and cancer, according to Duringer.

Health Suggestions for Summer.

Those doctors who consider themselves guardians of the health of their patients may properly drop a few words of advice regarding the important matters which the laity should know during the several seasons.

Parents should more generally instruct children in the hazards of summertime, and may need to be reminded of their responsibilities. While certain diseases are less prevalent in warm weather, the larger scope of outdoor activities brings the dangers incident to bathing, automobiles, drinking infected water, the use of fruit and vegetables in unwholesome condition, and the danger of contact with ivy and dogwood.

It is evident that children are often neglected although apparently representing families in comfortable circumstances. Automobile accidents especially furnish a text for instruction, for the reason why there are not more children killed or injured is due more to the caution of operators than to careful behavior on the part of children. Typhoid may be a vanishing disease, but it is not down to an irreducible minimum among returning vacationists and summer diarrhoeas still exist. Proper clothing is

Conserving Health of Pennsylvania's Children.—Dr. C. H. Miner, Secretary of the State Health Dept., at the meeting of health officers, at the Penn. State Sanatorium, Mont Alto, stated there were 800,000 undernourished children in that State. He said:

"I feel convinced that the taxpayers get a better return for money spent on the prevention of disease than for any other of his taxes. In the saving of lives from two diseases alone, typhoid fever and tuberculosis, there is a return of 400 per cent. on the money invested. We must spend more time and money on the education of the public in personal hygiene, so that physical defects may be corrected, malnutrition prevented and communicable diseases better controlled. We need more public health nurses and trained medical health officers, especially in the rural districts and the coal regions. The most important work for the future is to reduce the infant mortality rate. About 220,000 babies are born in Pennsylvania every year. In 1923 a total of 18,349 died—that is, 85 babies out of every 100 born died before they were a year old, most of them in the first month of life."

Auscultation in Pulmonary Tuberculosis.—I have had a large experience in treating chronic pulmonary tuberculosis, and I am sure that Paterson greatly exaggerates the harm which may result from auscultation. I can't remember any cases that it has harmed. It of course should not tire the patient. These patients should be auscultated at reasonable and not too long intervals. In hospital work this interval should not be longer than a month. In cases with an acute process, at least once a week. Auscultation is the greatest means at our command to know how the process in the lung is acting and if done quietly will not produce autoinoculations. Even if the patient is doing well he should have complete physical examinations at regular intervals. These intervals should be every two or three months

at the outside and should be thorough so as to obtain full knowledge of the patient's condition. At this examination the throat, larynx, abdomen, and testes should always be examined. . . . There is practically no danger from the examinations if properly made.—Hugh M. Kinghorn: *The Cure of Pulmonary Tuberculosis by Rest and Exercise*, Boston.

Facetious Items

An elderly lady was visiting The University Hospital in Oklahoma City. "Poor boy," she said to an ex-soldier who had been wounded, "you must have been through some pretty tight squeezes." At this he turned a violet scarlet and stuttered, "Well, madam, the nurses here have been pretty good to me for a fact."—Whirlwind.

Doctor.—Of what did your father die?

Patient.—They said calvary mortis.

Doctor.—And your mother?

Patient.—Oh! nuthin' serious.

Doctor.—Well what did the doctor call it?

Patient.—He said it was the brides disease, but she was an old woman and a widder.

A Rogues' Gallery.—An elderly man of ultra-convivial habits, but withal learned and bookish, was haled before the bar of justice in a country town.

"Ye're charged with bein' drunk and disorderly," snapt the magistrate. "Have ye anything to say why sentence should not be pronounced?"

"Man's inhumanity to man makes countless thousands mourn," began the prisoner into a flight of oratory. "I am not so debased as Poe, so profligate as Byron, so ungrateful as Keats, so intemperate as Burns, so timid as Tennyson, so vulgar as Shakespeare, so—"

"That'll do, that'll do," interrupted the magistrate. "Ninety days. And, officer, take down that list of names he mentioned and round 'em up. I think they're as bad as he is."—American Legion Weekly.

Looking About.—Copy of a letter received by a young widow, from a man 73 years old, now occupying the house, formerly the home of said widow.

Well—Mrs. C. i supose you will be suprisid to hear from me but you know wonders never cease you know i have thought for a long time if i should lose my wife i would like you for a mate and shurely i dont think she can last long so i thought i would speak in time it wont do any harm as i can see i didn't know but you would like to live in that house again so if i am rong kindly forgive me and no one will ever be the wiser if you dont want me Just tell me so and i will love and respect you for it

Sincerely yours.

Worse.—"Did the speaker electrify his audience?"

"No, he merely gassed it."—Williamette Collegian.

Journal of The Medical Society of New Jersey

Published on

the First Day of Every Month



Under the Direction

of the Committee on Publication

Vol. XXI, No. 8

ORANGE, N. J., AUGUST, 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

PALLIATION IN CANCER OF THE UTERINE CERVIX AND CAN- CER OF THE BREAST*

By Edgar A. Ill, M.D.,
Newark, N. J.

Mr. Chairman and Members of the Medical Society of the State of New Jersey:

It is with fear that I present to this Society my paper, whose subject is "Palliation in Cancer of the Uterine Cervix and Cancer of the Breast." My experience with radium and x-ray has been only four and one-half years. I have therefore based my conclusions on the work of others. I hope at least it will bring about a discussion on this subject. Discussion is a valuable part of any subject as presented before a body of medical men. Discussion may show my paper to be worthless. I wish if possible, to present the present situation in the treatment of cancer of the uterus and cancer of the breast. Our results in the treatment, of course, are primarily dependent upon early diagnosis and early application of the treatment. I know this statement has been made many times and you are probably tired of hearing it, but it is a prerequisite. Patients come to us with this terrible affliction and want help. What have we to offer them? I do not think that surgeons would be much impressed by their results if they would consider how many cases present themselves, how many are cured and how many have received real palliation. The journals for the past three or four years have contained many papers on statistics in regard to the results of surgical operation for malignant diseases. These investigations I believe have been greatly stimulated by the work of surgeons who have added radium and x-ray to their

armamentarium, and the work of the American Society for the Control of Cancer. They would not have come into the field if their present work had been satisfactory.

These statistics must be very carefully investigated. A man will unconsciously make his statistics conform to his impressions. As I have said before, statistics should be based on facts, that is how many patients apply, how many receive palliation, how many are well at the end of five years. When we compile statistics on pneumonia we state how many patients have had pneumonia, how many have gotten well. We do not say how many patients were good subjects and what percentage of these have gotten well.

It is our duty as medical men if possible to recognize cancer in its earliest stages, and to remove it surgically in the most radical way known to us, if it is still in the primary stage and where we know it is surgically removable. This has been developed during the past 40 years as the most efficient cure. I believe that until some physical therapeutic measures are developed, which will give a greater number of cures and a larger amount of palliation with less discomfort and danger to the patient, this method must not be changed.

At one of the conferences which were held during the past winter, at the Memorial Hospital in New York, on the treatment of cancer of the breast, a patient was presented who had a large mass in the breast fixed to the chest wall. There was extensive involvement of the axillary glands and masses above and below the clavicle. A prominent surgeon present was asked what he thought of this patient's chance with a surgical operation. He said about 10 per cent. Dr. James Ewing immediately took the floor and very quickly convinced the audience that this patient's chances surgically were nil. Again at the

*Read at the 158th Annual Meeting of the Medical Society of New Jersey, June 6, 1924.

Academy of Medicine in Newark, in a discussion on the treatment of gall bladder disease, it was said if cancer of the gall bladder or liver is suspected, the patient should be opened and given a chance for surgical removal. I do not know what chances the speaker thought the patient had and why the patient should go through a surgical operation for a chance which we all know does not exist. I cite these two little stories not as a criticism of anybody's work or ideas, but I wish to bring to your attention the falsity of the idea that when cancer is cut out, it is out, when as a matter of fact when cancer is cut out it usually returns. It has been my providence to be particularly interested in cancer of the uterus and cancer of the breast.

I shall now take up the consideration of malignant diseases of the uterus. It is not the scope of my paper to take up a long discussion of the differential pathological diagnosis fully realizing that the different types of growths vary in their response to treatment. We are interested as practicing physicians and surgeons in the diagnosis and treatment. The diagnosis of cancer of the uterus certainly can be made in any doctor's office without a microscope, I believe in 95 per cent. of the cases. In the first place unusual bleeding is present in about 85 per cent. and a bloody, watery discharge is present in about 95 per cent. of the cases. Those figures are taken from statistics from a very able investigation of the pathological and clinical study of cancer of the cervix by Carl H. Martzloff and published in the Bulletin of the Johns Hopkins Hospital, June, 1923. I do not think there is any discussion on this subject, so we as physicians should not only urge our patients to be examined where such symptoms are present, but we should never fail to have them apply to our local hospitals or offices for careful examination. The diagnosis has already been practically made and the physical examination is largely a confirmation. With a woman in a good knee chest position, with good light, the field is carefully sterilized. A small sterile curette is passed into the body of the uterus, the cervical canal and cervix. If small pieces of tissue are scrapped off as easily

as you would scrape off pieces of wet bread, you can almost always positively say that this is cancer. This can be better seen when the ulcerations are present in the cervical canal and cervix, and where you can see the curette pass through this tissue. There is no other condition in the cervical canal or cervix which will scrape off just like this. Inflammatory erosions of the cervix in no way act like this. I have never hesitated to tell the family of my diagnosis of cancer of the uterus by this method and I do not think that a pathologist has ever returned an adverse diagnosis. Please do not think that I say this with an idea of conceit on my part, but I wish to impress upon you the simple fact that this diagnosis can be positively and readily made. I, of course, always send this tissue to a laboratory for confirmation.

Operations for cancer of the corpus uteri where the disease has not gone beyond the body, have been very successful. We have looked up a series of patients operated upon by my father, Dr. Edward J. Ill, as far back as 25 years and did not find a single patient who had a recurrence. It is generally accepted by surgeons as well as radiologists that this is undoubtedly the operation of choice. However, we certainly have patients come to us where the surgical procedure is not possible. Radiation is then the method of choice.

I have treated three cases of cancer of the body with radium where the diagnosis was confirmed by a pathologist. Eight weeks later these patients were subjected to hysterectomy and a very extensive examination of the uterus failed to disclose any cancerous tissue. While the operations were most successful, the field is open to the radiologist in that there is no primary mortality. The operative mortality presents a large per cent. in different clinics from 15 per cent. to 25 per cent.

Conditions are not similar in cancer of the cervix. As I have said before it is fair to base our statistics on the number of patients who apply for treatment, the number of patients well at the end of five years, the number of patients who have received palliation. You will see this chart and a comparison of the work as presented by

	Number of cases	No. cases treated	Immed. mortality	No. cases who rec'd no treatment	5 year cures	% of cases who applied	No. cases who rec'd no palliation
Martzloff	387	178	25	209	40	10%	209
J. G. Clark	144	144	0	all treated	15	10%	large no. as shown by my cases

Martzloff with that of a series of patients treated with radium in the Gynecological Department of the University of Pennsylvania under the direction of Dr. John G. Clark.

I have selected the work of these two men because their statistics are based on facts and because their figures are so similar. You see, 387 patients applied for treatment, 178 or 46 per cent. were considered operable, 25 patients or 14 per cent. died of the operation, 209 cases received no treatment, 40 were well at the end of five years, which was 10 per cent. of the patients who applied. There were 209 patients who received no palliation. Martzloff has given the incidence of so called five year cures as 26.6 per cent. It is 26 per cent of the number of cases operated on. 144 patients applied for treatment at the University of Penna. 144 patients were treated. There was no immediate mortality. All the patients were treated. 15 patients were well at the end of five years or 10 per cent. of those who applied. 27.2 per cent. of the operable cases were well at the end of 5 years. Although only 15 patients remained well at the end of five years all the rest received palliation to a very marked measure at the expense of a few days in the hospital with no discomfort or danger which is attendant to an attempt of surgical removal.

Let me quote from a personal communication of Dr. John G. Clark of Jan. 11, '19. "To my mind, one is not a friend to the radium cause to talk too loudly about the cures. Certainly we have gained enough in the palliative treatment to more than justify its use."

In a series of patients operated on at the Johns Hopkins Hospital the operative mortality ran as high as 70 per cent. My experience with radium has covered four and one-half years. During this time I have refused treatment to only two or three patients. These were moribound and died a few days after they were admitted to the hospital. I have had 170 patients with cancer of the cervix, of whom 52 have passed three years. Of these, 48 per cent. are living and well three years. Of those that are considered dead 13 have been lost track of. Even the very serious and extensive cases were greatly relieved during

a long part of their existence. The discharge and bleeding had ceased, the discomfort of treatment was very little and the mental condition has been generally one of hope and comfort.

I shall compare with this chart the average from seven surgeons from statistics which have been compiled by Dr. John G. Clark and presented before the Southern Surgical Society in December, 1923.*

	RADIATION		
	Operable	Inoperable	Borderline
Five Radiation Workers	45%	10%	31%
J. G. Clark	27.2%	6.7%	not given
	18%	3.3%	

There was a total of 2,580 cases who applied for treatment. 1,247 were treated and there was an operative mortality of 14.5% or 180 cases. 1,333 cases received no treatment. The five year cures of patients operated on was 37%. The number of cases that applied and were well at the end of five years was 15%. Let me compare this with the work of five radium workers which was presented in the same series. Of the operable cases, as you will see by this chart, 45% were well at the end of five years, where Dr. John Clark had 27% well at the end of five years. Of the inoperable cases there were 32% well, where Dr. John G. Clark had 6.7% well. I present these merely to show you that actually radium has shown a very much higher percentage of cures in the operable cases, a higher percentage of cures in the inoperable cases with the addition of a large and extensive amount of palliation which these unfortunate patients receive.

These statistics will vary a great deal with different surgeons. One man will consider a patient inoperable, another will say operable. A series of 234 cases in the gynecological service of St. Michael's Hospital over a period of ten years up to 1900, only 15 patients were found to be operable. You can see how many patients received little or no treatment except morphine.

Diagnosis of cancer of the breast is not always as clear cut and distinct as cancer of the cervix. However, an irregular nodular tumor fixed in the tissues is suspicious. There may or may not be retrac-

	SURGERY					
	No. cases	No. treated	Mortality	Rec'd no treatment	5 year cures	% of cases applying
Seven Surgeons	2580	1247	14.5%	1333	37%	15%
Martzloff	387	178	25%	209	26.6%	10%

tion of the nipple. There may or may not be a fixation to the skin. There may or may not be fixation to the chest wall. There may or may not be discharge from the nipple. There may or may not be axillary glands. There is seldom pain. Axillary nodes are often present when a benign tumor is present in the breast and are often not felt in malignant tumors. There is a great diversity of opinion as to which cases are operable and which inoperable. In a very able paper by Dr. J. E. Sadlier, and published in "Surgery Gynecology and Obstetrics" in February, 1923, 70 cases applied for treatment and Dr. Sadlier says all patients were operated on and all were treated. These patients were over a twenty year period. At the end of that time 23 patients were alive, or 32.8%. Some of these cases were recent. These statistics are interesting in that all patients who applied were treated, but they do not give an accurate idea of the number of patients who remained well and who are ordinarily considered operable. For example, Halstead has given 70% of cures in patients without glandular metastases and 25% in patients with glandular metastases. While Mayo has given 69% without glandular metastases and 19% with glandular metastases. From the classification as given at the Memorial Hospital in New York the inoperable cases were classified as follows:

A primary inoperable breast carcinoma is one in which one or more of the following factors are present:

A Fixation of the breast tumor to the chest wall.

B Involvement of the supraclavicular nodes.

C Definite involvement of the opposite axillary nodes.

D Diffuse subcutaneous nodules.

E Diffuse inflammatory carcinoma involving a considerable skin area.

F Chest metastases pleural or mediastinal.

G More remote metastases.

All surgeons will not perhaps be in accord with these indications of inoperability.

In this group of cases I have seen little palliation with operation. Patients' lives are not prolonged, their pain is not relieved and they have the additional discomfort of this radical operation. I have myself operated on a number of these patients only to find a very rapid recurrence locally and in the lung, mediastinum and bones. In addition, I believe that the operation is not only not palliation but directly the cause of

metastases. Dr. John F. Hagerty of Newark, about 4½ years ago sent me a patient with cancer of the tongue with extensive glandular involvement of the neck. At the time I advised radiation of the growth in the mouth and operation and radiation of the glands. He then drew my attention to the fact that in his hands this had never cured a patient and he believed it hastened recurrence. I therefore treated this man without any operation and he has remained well 4½ years. I have lately taken this question up with Dr. James Ewing of New York and I am going to take the time, if permissible, to read his letter to me, in answer to my inquiry:

"I think it a very general impression among pathologists that cancer of the cervix uteri, untouched, kills in the great majority of cases, by occlusion of the ureters, and without extension of the disease beyond the pelvis. Even the lymph nodes may escape. Kroemer found the pelvis nodes free in 66% of his fatal cases. See my second edition p. 599. Corpus carcinoma is much more apt to extend widely

"With breast carcinoma much the same relation holds true, but distant metastasis will occur with many untouched cases. I have no figures since mammary cancer is seldom allowed to progress without operation, no matter how far advanced. I have a distinct impression that the dissemination is hastened and widened by unsuccessful operation. I have seen carcinoma remain in the confines of the breast for ten years. The breast cases vary widely in their tendencies in this respect, and I should prefer not to attempt to establish uniform rules for all types of cases. It is to be regretted that surgical enthusiasm has somewhat prevented attention to these important characters of unhindered carcinoma. As a fact, I do not remember one autopsy on untouched mammary cancer."

You can, therefore, readily see why I have an open mind on this subject. Let me now compare some statistics which by the way are very difficult to compare, because each writer seems to unconsciously try to make his statistics respond to his ideas. It has been almost impossible to find statistics which say how many patients applied, how many were treated, and how many were well at the end of five years.

This chart will show you a summary of the statistics of Dr. John Grenough of Boston, Chas. H. Peck of New York and Dr. Sadlier of Poughkeepsie. You can see how the percentage of cases, well over five

years, varies.* In Grenough's series there were five patients which had insufficient data. In Peck's series he had follow-up reports on 69 cases out of 195 passed five years. The question is what happened to the rest of these cases. Sadlier's report was most complete. He saw 70 cases, operated on all of them and had a complete follow-up on all of them. Let me compare these statistics with those of Dr. Burton J. Lee of New York. He has gathered this series from the work at the Memorial Hospital. The 1920 series is most interesting in that they had 83.3% cases living with radiation and 64.3% of the patients treated surgically, alive. These were of the primary operable cases. Of their primary inoperable cases up to Dec. 21, '20, or earlier, 64 patients were treated with radiation and 10 are alive, about 20%.

I realize perfectly that the statistics I have given are comparatively a small number of cases. It would be impossible to compare all the statistics which are published. You would soon find yourself in a muddle and I believe that if we are to form some conclusion as to the real value of surgery and the real value of radiation some standard of comparison must be adopted. All surgeons must classify their cases as nearly alike as possible clinically, as to operability and as to the result.

A great deal of work is being done with radium and x-ray at the present time and as I have said before, I do not think it would have come into the field if the previous work had been satisfactory.

In conclusion let me quote from an article by Dr. Chas. H. Mayo, in the *Annals of Surgery*, Sept., 1922. "Roentgen ray and radium in the treatment of cancerous growths have made marked progress in a very serious group of cases. Many early and some late cases, according to location and type have apparently been cured by such treatment."

Anyone who has worked with radiation

Total No. of cases	Total No. well at end 5 years	% well 5 years	% well without axillary glands	% well with axillary glands ⁽²⁾
103	22	21%	32%	19%
69	27	39%	24%	14%
70	23	32% ⁽³⁾		

(1) Grenough, Boston, Med. & Surg. Jour., Sept., 1921.

(2) Peck, Amer. of Surg., June, 1922, 69 cases out of 195.

(3) Sadlier, Surg., Gyne. & Obst., Feb., 1923.

is bound to be impressed with the very remarkable disappearance of cancerous growths without apparent destruction of the normal tissues and I feel that unless some more definite method of treatment is evolved, a great deal of work will be done with x-ray and radium and some definite conclusion as to dosage will be found and the percentage of cures over five years will be very much increased.

DISCUSSION.

Dr. Francis R. Haussling, Newark: I have enjoyed Dr. Ill's paper very much, and I agree with practically all that he has said. I think he has approached the subject in a very rational manner. I attribute this to the fact that he is primarily a surgeon. In my opinion, it makes no difference who applies the radium or x-ray or the surgery, but it makes a great difference who selects the patient, and in my opinion, it must be a man who has had some experience with the result of radium treatment and who has also had previous surgical experience. Dr. Ill stresses the question as to which method shall be applied to a given case, whether surgery shall be applied or whether radiation shall be applied. Of course, I think this is the crux of the situation. It makes a difference as to the location of the growth and the life history of this growth, the time at which it has been recognized. In the two locations under discussion today, that holds good, as to whether it is in the uterus or whether it is in the breast. Again, it makes a great difference as to whether it is in the body of the uterus or the cervix.

I think we are all agreed that if we have a method that gives us a high percentage of cures, we should not relegate that method until we have some method we are sure comes very close to it. Therefore, in carcinoma of the body of the uterus, I take the attitude that surgery shall be applied, because these cases if operated on early practically never have a recurrence. Carcinoma of the cervix, on the other hand, is a most unfavorable location. I don't believe that I have seen one case of carcinoma of the cervix in which the growth was still limited to the size of a five cents piece. The peculiar situation makes it difficult to handle it surgically, to get wide of the growth, and there is no use of applying surgery to any malignant unless you can remove it widely, macroscopically—I don't say microscopically, but macroscopically.

On the other hand, any one who has followed the results (palliation at least) of radium in carcinoma of the cervix can't fail but be markedly impressed to see these growths of considerable size melt away and the cervix again look quite normal. Of course, the cases haven't been followed long enough to know whether they stay well, but the immediate result is remarkable. Therefore, I believe practically every case of carcinoma of the cervix is now out of the surgeon's hands and in the hands of the radiologist.

When we come to carcinoma of the breast, this is more favorable for surgical application. Reports show that where there is no glandular involvement, about sixty to seventy

per cent. of the cases stay well, while if there is slight glandular involvement something like twenty per cent. stay well following surgical intervention. Again, the location here adapts itself very nicely to surgical removal. Which cases shall be removed (and this is the crux of the situation) by surgery, and which shall be referred for radiation, or which shall have a combination?

If there is a tumor in the breast, whether it is benign or malignant, it should be investigated, because we know that malignancy can be planted on or can occur in benign tumors. Therefore, every tumor in the breast should be operated on to establish the diagnosis, and if it is a doubtful case and is proven by frozen section to be malignant, a wide excision should be made. My rule has been to consider malignant breast cases inoperable if there is supraclavicular glandular involvement. I have never seen one of these cases stay well, so why operate? If there is fixation of the breast wall, I see no indication for operation because I have never seen a case stay well with operation. Where a case is on the borderline, I insist on x-ray of all the bones, especially the long bones and the spine, because cancer of the breast is one of the three most frequent tumors to metastasize in bones, and why excise the breast if there are already bony metastasis?

In removing cancer of the breast, I always do a radical operation and then refer it for radiation. Of course, I don't think any of us know how much good that does, but if radiation will give us a larger percentage of cures in inoperable cases, why shouldn't it give us a larger percentage of permanent cures in operable cases that ordinarily would have recurrence? (Applause.)

Dr. J. Thompson Stevens, Montclair: Last evening I met a patient here whom I have recently treated with roentgen rays, and I would like to present this lady before the society, if I am not out of order. This lady was referred to me by Drs. E. Z. Hawkes and Roy Griffith, of Newark. She had had one breast removed which was followed by a recurrence, which was again removed surgically together with two metastatic nodules, one on the opposite lateral wall of the thorax, one posteriorly on the shoulder. Upon examination it was found that there were metastatic glands in both cervical lymph chains, both axillae, the opposite breast, and a necrotic recurrence at the site of the primary growth. There was shortness of breath and nonproductive cough, roentgenograms of the chest showing these symptoms to be due to metastatic growths at the roots of both lungs. The complexion was of a deep yellow. These findings with the great pain presented about as hopeless a patient as it is possible for one to imagine.

The necrotic, recurrent was destroyed thoroughly by means of electrothermic coagulation, or by endothermy as Dr. George A. Wyeth prefers to call it. The chest was radiated with roentgen rays. The coagulation field has healed beautifully, all metastatic glands have disappeared including those at the roots of the lungs. There is no pain, cough, or shortness of breath. The complexion is now about normal, and almost all of the weight lost has been regained.

At the Mayo Clinic last December I had the honor of presenting a paper, "Modern Methods in the Treatment of Cancer of the Breast." At that time I was able to report 72 per cent. of the cases well who had been treated by various combinations of surgery and radiation therapy. In the cases which were radiated either before or after operation or both I was able to report 93 per cent. well three and one-half years after treatment. They are now four years and one month well. I, of course, had the best of surgery to aid me in this work. This discussion, I believe answers the question that Dr. Haussling has raised when he asks what the results would be in the operable cases if they are promptly radiated as a routine? With surgery alone about 22 per cent. recover. The figures of these hospitals which Dr. Ill has shown are very difficult to compare with the figures you would find in private cases, because these cases are generally known as the "rotten" cases, a good many of them, anyhow. They live under unhealthful conditions, their food is not good, etc. They are the most unsatisfactory cases one can get.

It is important to classify the patient who is suffering with a malignancy. Is the disease localized to a part or organ? If so it should be operated and thoroughly radiated promptly as a routine. The second class are those known as borderline, those with axillary metastasis. If roentgenograms of the chest do not show metastatic glands within the chest these cases are operable too. However, best results will be obtained in this group if they are given preoperative radiation.

As you well know it is a proven fact that a properly radiated cancer will not produce a metastatic new growth if transplanted. Radiation therapy is again indicated promptly following operation. In the third class are those who are definitely inoperable, those with supraclavicular glands for instance. In almost every one of these cases roentgenograms of the chest will show deep metastasis within the chest. However, some of these cases enter the operable class following radiation. In the fourth class we find those known as hopeless. They are treated with small doses of roentgen rays only, merely to relieve pain and to make their end more bearable. The last group are the recurrent ones. Their treatment depends upon their classification as just outlined.

I regret that my time is up because I wanted to discuss the treatment of malignant disease within the pelvis, the uterus, particularly the cervix with radium, roentgen rays, and electrothermic coagulation. I have enjoyed very much this excellent presentation of Dr. Ill's.

Dr. Shields, Cincinnati, Ohio: I would like to give my personal experience of forty-odd cases, rayed from 1908 to 1910, all dead within three years. The patients were rayed immediately after operation and they were all dead before three years had passed. Two years ago, while traveling through Germany, I visited Professor Starck's clinic at Monheim, as I had heard so much before leaving my city in reference to the results of deep therapy. I made an ass of myself when I quoted my friend, because when Professor Starck showed me his case book it showed death, death,

death, death. How it is possible to get the large percentage of cures, after five years, mentioned by the last speaker, I cannot understand. In the cases which I reported as having died, there was a microscopic examination made in each and every case. They are dead.

Dr. Edgar A. III, closing: Dr. Shields' report is very interesting. I was in Germany the winter before last and I spent some time in Frankfurt and I took the trouble to see patients who had been operated on or treated back as far as 1914. Either they are liars or else they don't know anything about cancer. That is to say, it may be that the original diagnosis was a lie and the patient didn't have cancer to begin with. But those patients that I saw certainly were well. I have seen any number of cases where the patients are well after being operated on for cancer, and I will recommend Dr. Shields to Memorial Hospital in New York. If he will go there any Thursday morning at ten o'clock they will show him any number of patients who have been well for over five years.

ROENTGEN RAY THERAPY IN HEMORRHAGIC METRO- PATHIES AND UTERINE MYOMATA.*

By Jacob Roemer, M.D.,
Paterson, N. J.

The application of Roentgen rays in the treatment of uterine myomata and hemorrhagic metropathies had its beginning in 1904. The first man to treat successfully uterine myomata was the Frenchman, Courmelles. In the same year Deutsch, of Munich, published an article on the same subject. In 1905, good results in the Roentgen treatment of uterine myomata were reported by Laquerriere, Imbert and Kocher. In 1906, Laquerriere and Courmelles reported a large series of cases of uterine myomata successfully treated with the Roentgen ray. In 1909 Albers-Schoenberg published his first experience on this subject. Then followed publications from many workers, notably, Bergonie, Bordier, Faber, Abel, Haenisch, Pfahler, Goerl, Kroenig and Gauss, Wetterer and others.

In 1919, Kreutzman¹ reported 200 cases of uterine myomata successfully treated with Roentgen ray and urged close co-operation between the surgeon and Roentgenologist. In 1920, Pfahler² reported his experience extending over a period of fourteen years as most satisfactory. In 1922, Bèclère³ reported 700 cases of uterine myomata treated with the Roentgen ray, only seven of which were unsuccessful. Those

seven cases were operated upon and in each case a submucous fibroid was found. In spite of this the author insists that submucous fibroids are no contra-indication to Roentgen treatment. Bèclère makes this statement,⁴ "An abdominal tumor with all outward manifestations of uterine fibromyoma that does not diminish in size after proper Roentgen treatment is not a fibroid or, at least, not purely of a fibroid nature." Among the last 300 cases reported by Bèclère he observed four cases in which intra-uterine pedunculated fibroids were expelled after which the bleeding ceased. One of these was the size of an orange, the others were smaller.

Splendid results in the Roentgen treatment of hemorrhagic metropathies are reported by Wiesner-Aschaffenburg, Fraenkel, Albers-Schoenberg, H. E. Schmitt, Gauss, Faber, Matthaei, Reifferscheid, Gfroerer, Kroenig, Pankow, Haendly and others. (5). Gfroerer reports 97.5% cures in climacteric bleeding and 2.5% improvement. Kroenig as well as Pankow report 100% cures. Wetterer reports 26 cases of uterine bleeding and dysmenorrhea which yielded to Roentgen Therapy.

The principle involved in the treatment of uterine myomata and the hemorrhagic metropathies is based upon the fact that if the ovaries are exposed to a definite amount of radiation they cease to function and as a result menstruation is suppressed. It is a known fact that uterine fibroids never develop before puberty nor after the onset of menopause. It is, therefore, very reasonable to suppose that it is some disturbance in the internal secretion of the ovaries that brings about changes in the endometrium and myometrium resulting in the above mentioned conditions. These disturbances in the internal secretion of the ovaries manifest themselves in altered menstrual periods which may be in the form of diminished or increased flow of blood or the absence of any bleeding.

Seitz believes that qualitative changes in the internal secretion of the ovaries stimulate the uterine muscle fibre to proliferation resulting in fibroid formation. This view is supported by Schickele, Schneider, Aschner and others. Lahm applies the same principle to the metropathies and claims that neither the metropathies nor the myomata are the actual causes of uterine bleeding and that these conditions go hand in hand with disturbed ovarian function.

Amenorrhœa.—Schroeder divides Amen-

*Read at the 158th Annual Meeting of the Medical Society of New Jersey, June 6, 1924.

orrhoea into two grades, a mild form and a severe form and explains them as follows: In the mild form the ovum fails to mature although follicles keep on growing but atrophy prematurely. In this condition the genitalia remain normal. In the severe form the follicles grow very sparingly and there is absence of the turgor hormones and atrophy of the genitalia.

Polymenorrhoea.—Schroeder explains this condition to be due to lack of normal inhibition of the corpus luteum upon the ripe follicles although the ovum and corpus luteum have a normal life cycle, therefore the proliferating phase is shortened.

Metrorrhagia and Menorrhagia occurring at puberty or later in life or at the climacteric change have, no doubt, as their cause a disturbed ovarian function. We should, however, exclude here uterine bleeding due to cervical erosions, malignancy and other diseases.

The character of Roentgen treatment for the above mentioned pathologic conditions depends upon several factors. In the treatment of amenorrhoea it is advised to give to the ovaries a stimulating dose. This is placed by different authorities from 1/5 to 3/4 of a castration dose. Flatau⁵ reported twelve cases of amenorrhoea treated by him with return of normal menses in ten cases. In these cases he gave from 1/5 to 1/4 of a castration dose below umbilicus front and back. Thirty-eight cases received treatment to the ovaries only and of these twenty-six had return of normal menstruation. Thaler⁶ treated fifty cases for secondary amenorrhoea and of these thirty-six had return of normal menses. Groedel⁷ also reported good results in the treatment of amenorrhoea.

In the treatment of menorrhagia and metrorrhagia either a temporary or a permanent castration dose is given, depending upon the age of the patient.

Dysmenorrhoea.—Graff⁸ reported excellent results in the treatment of dysmenorrhoea in young girls. Werner⁹ also reported excellent results in the treatment of severe dysmenorrhoea in young girls. Of twenty cases treated by him with temporary castration, seventeen had return of normal menses. Temporary castration, if properly carried out, produces amenorrhoea lasting from one to two years with the return of normal menses. A dose sufficient to produce temporary sterilization destroys only the ripe follicles and leaves the primordial follicles uninjured. A dose sufficient to

produce permanent sterilization destroys all the follicles but does not effect the interstitial glands and it is, probably, for this reason that castration by the Roentgen method is not accompanied by as severe a nervous symptom-complex as is seen in surgical castration or even the natural menopause.

Temporary castration in young girls and young women can be accomplished by giving from 5 to 10% less than the regular castration dose. Of course, when carrying out such treatment one should very carefully measure the dosage. The writer succeeded in producing amenorrhoea in three young women, 24, 26 and 28 years of age, by giving 15 per cent. of an erythema dose. This is a little less than half of a castration dose and he firmly believes that these women will have a return of normal menses within two years.

Uterine bleeding which accompanies chronic inflammatory conditions is decidedly benefited by temporary castration. During the time that the patient remains amenorrhoeic the inflammatory condition subsides and normal menstruation is then established.

Pape, Mayer and Mansfeld¹⁰ have for the past three years or more been practicing one-sided castration for the relief of uterine bleeding in young women and girls at puberty. They claim good results without producing amenorrhoea.

Uterine Fibroids.—The treatment of uterine fibroids is based on the same principle as that of the hemorrhagic metropathies,—that is, suppression of the ovarian function. In cases of young women a temporary castration should be produced and during the interval of time that the patient is amenorrhoeic the fibroid may entirely regress leaving the patient with a normal uterus. A patient so treated may subsequently become pregnant and give birth to normal children. Cases of pregnancy following temporary castration are recorded in the literature by the following authorities:

Edelberg,¹¹ Koehler,¹² Stern,¹³ Werner,¹⁴ Holzknicht,¹⁵ Frankl,¹⁶ Brettschneider,¹⁷ Kupferberg,¹⁸ Benthin,¹⁹ Pankow,²⁰ Wetterer,²¹ Zikmund,²² Steiger,²³ Flatau,²⁴ Seufert,²⁵ Heipmann,²⁶ Vogt,²⁷ Nuernberber,²⁸ Schumann,²⁹ Heimann,³⁰ Linzenmeier,³¹ and Pfahler.³²

In women of forty or over, permanent castration should be produced. In fact, a dose that would produce temporary castration in young women is sufficient to pro-

duce permanent castration in older women. Grodel found that the high nervous tension occurring at the climacterium without bleeding can be relieved by Roentgen treatment. The success of Roentgen therapy in such cases is probably due to the destruction of some remaining follicles with faulty internal secretions. I had occasion to treat a woman of 52 for this condition and obtained satisfactory results.

What role the Roentgen ray plays that brings about retrogression of a fibroid tumor is still a disputed question. Some authorities maintain that it is the action of the rays on the tumor itself. This theory seems to be very unreasonable. A fibroid tumor is composed of muscle cells which would require, at least, five times a castration dose to be destroyed. Furthermore, applying the rays through a small portal of entry, (6x8 c.m.) directly over the ovaries, with hardly any rays going to the tumor, causes retrogression of the tumor just the same. Another theory advanced is that the endarteritis set up by the rays starves the tumor. This theory is just as unreasonable as the first, as 34 per cent. of an erythema dose given at one setting will never produce this condition. The most reasonable and convincing theory is that the suppression of the function of the follicular apparatus causes retrogression of the tumor. It is commonly agreed that it is some disturbance in the internal secretion of the ovaries that brings about uterine fibroid formation. It is, therefore, reasonable to suppose that suppression of that function would cause disintegration of the fibroid.

Contra-indications to surgical treatment of uterine fibroids are: Obesity, diabetes mellitus, severe anemia, non-compensated heart lesions, so-called myom-heart, pulmonary tuberculosis, nephritis and refusal to submit to operation. In none of the above mentioned conditions is Roentgen therapy contra-indicated. Contra-indications to Roentgen therapy are pregnancy, malignant changes in the uterine wall, degeneration of a fibroid tumor, calcified fibroid, ovarian neoplasm, pedunculated fibroids that become twisted, incarcerated fibroids or any fibroid that produces severe pressure symptoms. Submucous fibroids respond well to Roentgen therapy excepting when they are situated at the cervix and present through it, and in such cases should be removed. Sarcomatous degeneration of a fibroid tumor is no contra-

indication to Roentgen therapy. But, in such cases, a sarcoma dose should be administered. Acute or chronic salpingitis is no contra-indication to Roentgen therapy for, as a rule, with the cessation of menses the salpingitis improves.

Technic.—Seitz and Wintz have shown that if 34 per cent. of an erythema dose is applied to the ovaries at one sitting, castration results. If such treatment be given at the end of a menstrual period then the next period is avoided. Many Roentgenologists still adhere to the old method of fractional dose of medium hard rays, filtered with from three to five m.m. aluminum and a short focus skin distance. To that method there are many objections; it takes months to produce castration; more injury is done to the over-lying tissues; it is time-wasting to patient and radiologist and absolutely dangerous in anemic patients, as after one or two fractional doses the next menses may be so severe as to threaten the life of the patient. This method is unscientific, as the exact quantity of radiation necessary to produce castration cannot definitely be determined and it would certainly be dangerous to attempt temporary castration by this method.

In my own practice I use a slight modification of the Seitz and Wintz method as follows: Tension at the terminals of the tube 215,000 volts, 4 milliamperes of energy, focus skin distance 50 c.m., filtered with 0.75 m.m. copper and 1 m.m. aluminum. This formula is used over a portal of entry 20x20 c.m., including the uterus and adnexa, front and back. The average time necessary to produce castration at one sitting is two hours. With this technic it is rarely necessary to give more than half of an erythema dose to each portal without producing even a slight erythema on the skin.

I have followed this method for the past fifteen months and find it most satisfactory and it has never been necessary to repeat the treatment. Among a number of cases that were castrated for fibroid tumor of the uterus, I like to mention briefly three which were treated about a year ago and which illustrate the usual course in such cases:

Case No. 1. R. M., single, age 48. Intramural fibroid reaching umbilicus. Menorrhagia for the past three years. Patient is very weak and anemic, hemoglobin 30%. Castrated July 3rd, 1923. Bleeding stopped promptly and patient had no Roent-

gen sickness except a slight diarrhea. Five days later there was recurrence of slight bleeding lasting 24 hours. Patient gradually regained health and examination made by her physician May 20th, 1924, shows a marked reduction in the size of the tumor.

Case No. 2. A. W., married, age 47. Had five children. Fibroid tumor of uterus size of large orange. Severe metrorrhagia for past six months. Patient very weak and anemic. Hemoglobin 32%. Patient brought to my office in an ambulance. Castrated May 21st, 1923. Continued to bleed slightly at intervals for three weeks and has not bled since. She is now perfectly well and examination shows entire disappearance of the tumor April 30th, 1924.

Case No. 3. E. V., married, age 44. Had one child. Fibroid tumor of uterus reaching about two inches above umbilicus. Menorrhagia for the past six years. Patient's general condition good. Castrated July 17th, 1923. Had one period after treatment and has not menstrated since. Examination made May 19th, 1923, shows the uterus to be about the size of a baseball. Patient is in excellent condition.

In considering Roentgen ray therapy the following advantages should be recognized. There is no anaesthesia, shock or mortality. It is economic both in time and expense. In young women, this method does not exclude the possibility of subsequent pregnancy.

In conclusion, therefore, it is to be emphasized that, in the above mentioned diseases, Roentgen therapy is the method of choice, provided none of the contra-indications referred to exist, and provided also every possibly method has been employed to establish a correct diagnosis.

BIBLIOGRAPHY

- 1 Kreutzmann, Am. J. of Obstr., 1919.
- 2 Pfahler, N. Y. Med. Journal, 1920.
- 3 Beclere, Arch. d Electric Med. et de Physiotherapie, 1922.
- 4 Beclere, Strahlentherapie, Vol. 14, 1922.
- 5 Flatau, Centralblatt fuer Gyn., 1922.
- 6 Thaler, Centralblatt fuer Gyn., 1922.
- 7 Groedel, Muench Med. Wo., 1922.
- 8 Graff, Strahlentherapie, Vol. 4.
- 9 Werner, Arch. fuer Gyn., Vol. 106 u 110.
- 10 Pape, Mayer and Mansfield, Strahlentherapie, Vol. 14.
- 11 Edelberg, Berl. Kl. Wo., 1914.
- 12 Koehler, Zeitschr. fuer Gyn., 1918.
- 13 Stern, Am. J. of Obstr., Sept., 1915.
- 14 Werner, Arch. fuer Gyn., Vol. 110.
- 15 Holzknecht, Centralblatt fuer Gyn., Vol. 41.
- 16 Frankl, Centralblatt fuer Gyn., Vol. 24, 1921.
- 17 Bretschneider, Arch. fuer Gyn., Vol. 109.
- 18 Kupferberg, Strahlentherapie, Vol. 11.
- 19 Benthin, D. Med. Wo., 1920.

- 20 Pankow, Strahlentherapie, Vol. 9.
- 21 Wetterer, Handbuch der Roent. und Rad. Ther., 1919.
- 22 Zikmund, Soornik Lekarsky, Vol. 21.
- 23 Steiger, Schweizer Med. Wo., 1921.
- 24 Flatau, Muench Med. Wo., 1921.
- 25 Seuffert, Muench. Med. Wo., 1921.
- 26 Heipmann, Centralblatt fuer Gyn., 1919.
- 27 Vogt, Strahlentherapie, Vol. 11.
- 28 Nuernberger, Prakt. Ergebnisse der Geb. und Gyn., Vol. 8.
- 29 Schumann, Diss. Marburg, 1918.
- 30 Heimann, Strahlentherapie, Vol. 11.
- 31 Linzenmeier, Centralblatt fuer Gyn., 1922.
- 32 Pfahler, Quoted by Beclere, Am. J. Roent., 1922.

DISCUSSION

Dr. Ernest A. May, East Orange: One point I'd like to bring out again is that there is no contra-indication whatsoever to the treatment of myoma and the benignant hemorrhages in gynecology if one excludes from the treatment the pedunculated submucous and the infected myomata, which have to be treated surgically.

As Dr. Roemer already has said, the myomatous degeneration of the uterus must be due to a lack of function in the ovaries. In restoring this function by stimulation with the x-ray, we bring the uterus back to normal condition in 100 per cent. of the cases. That there is a connection between this function, which may consist of the secretion of a hormone, and the generative part of the ovaries, shows the experience, that some myomata go down in size by themselves after the cessation of the ovulation in the menopause. Here the inactivation of the generative apparatus leads to an additional secretion of this hormone. This inactivation of the follicle part and the stimulation of the hormone secretion can be produced artificially by the same dose of x-ray, but it is not necessary to put out of function the whole generative part of the ovaries, as we use to do in women beyond forty. In women who are expected to bear more children, the destruction of only the most ripe follicles is necessary to bring about a decrease of the myoma. Thus, the menses will stop for one to three years and then come back.

As a permanent sterilization demands a specialist thoroughly educated and familiar with his equipment, the temporary sterilization is one of the most difficult tasks in deep ray therapy. It requires minute measurements of both quality and quantity of the rays and a treatment given in one dose. One cannot be warned enough against the old method of sterilization by fractional doses. It is not only practically impossible, to obtain the right dose by addition of small amounts, but it exposes the patient to the greatest dangers, as the small dose, will lead to an increase of the hemorrhages.

Once or twice the menstruation may come back after treatment, but in a far diminished amount. This is due to the following very interesting fact.

The menstruation and also the menorrhagia are caused by internal secrets, the so-called hormones, which are produced by the corpus luteum menstruation is of the last ovulation. Suppose a ripe follicle bursts in the beginning

of May, its ovum traveling down the oviduct, then the follicle left behind in the ovary develop during the next two weeks into the corpus luteum which now, that in the middle of May, starts to send out into the system its hormone, the lutein. This lutein causes gradually within another two weeks the well known changes, at the end of which the menstruation takes place in the beginning of June, just in the same time when the next follicle is going to burst in the ovary. We now see that not the June ovulation but the May ovulation causes the June menstruation. To stop this June menstruation we have to destroy the corpus luteum of the May ovulation before it sends out its hormone, that is before the middle of May. One, therefore, only can promise a patient that her menses will not come back, if she undergoes the treatment right after her menses. At least in the first half of the intermenstrum. If treated in the second half, the patient slightly will flow again because the hormones causing the next menses are already in the system. This menstruation after x-ray treatment, therefore, is not to be considered as a sign of non-sufficient dose of x-ray.

As to speak about the results, all my cases succeed in a cure. Even the most abundant hemorrhage stopped the latest the next day after the treatment. The largest myoma I have treated in this country reached above the umbilicus and went down to a normal uterus after one sterilization dose within four months.

Since x-ray therapy shows such good results we do not advise any more operations in these cases with a few exceptions only.

Dr. J. Thompson Stevens, Montclair: Both speakers have fairly, clearly, in fact, very clearly, gone over all of the factors which have to do with the Roentgen treatment of fibroids of the uterus, with and without hemorrhages. They have outlined that the fibroids which should be treated by Roentgen therapy are those of the superitoneo-intramural and submucous. There are one or two other conditions which cause excessive bleeding from the uterus which have not been mentioned. One is endometritis, and another might be called the idiopathic type—unable to find any cause for it.

In a young person suffering with endometritis, Roentgen therapy, to my mind, is not the method of choice for treatment. Last year I showed a number of charts on the screen here which showed measurements of both the Roentgen rays and radium rays on the surface and in the depths. We found that with the radium we only received a radiation of destructive proportions within a radius of three centimeters from the applicator. Since the ovaries are approximately in all cases five centimeters from the uterine canal, and since we have the thickness of the uterus between the applicator and the ovaries, there is a great chance of sparing the ovaries any detrimental radiation whatever by the application of a radium capsule from within the uterus. Then there are the cases that are idiopathic. Oftentimes by a radiation of the spleen, you can entirely control these hemorrhages without subjecting the contents of the pelvis to any radiation whatever.

Recently I had a patient fifteen years old, referred by Dr. Doremus, Dr. Hawkes, Dr. Teeter and Dr. Smalley of Newark. She had bled so profusely that she had been transfused two or three times to keep her alive. Dr. Hawkes opened the abdomen and found she had a considerable enlargement of the uterus and some diseased condition of the ovaries, which was accompanied by enlargement; also she had an endometritis. Ordinarily, I would have treated that patient with radium if she had had just the endometritis and the enlargement of the uterus, but the enlargement of the ovaries made me select the Roentgen rays. I gave a dose very much along the lines of the one suggested by Dr. Roemer and by Dr. May and the result was that this girl had a period the next month which lasted two days. The first day of the following period I subjected the spleen to a ten per cent. dose of Roentgen rays.

Dr. Edward J. III, Newark: This subject is a subject of the very greatest importance. I have lived long enough to go through the whole gamut of treatment of fibroid tumors, from the time that Haegar first recommended the removal of ovaries from the fibroids, until the present time of radium and x-ray. There is one very important matter in the treatment of radium and x-ray in selecting the patient (not selecting the case; I am not talking of that just now) to treat with this particular method. To treat with this particular method, you must have a patient of some intelligence. Some women, as long as they feel the tumor or know the tumor is there, or any vestige of it, will demand its removal because of their mental condition. They are constantly worried about the possibility of this becoming cancer, which you all have preached, and which I have been talking against for so many years. I have never seen a fibroid tumor undergo malignancy. It is constantly reported (and in the cases I looked up afterwards, I found it was a mistaken condition) that the patient probably had carcinoma of the endometrium before the operation.

Nine-tenths of the patients who come to us are patients who lack intelligence. If they still find a nodule there, or if they go to our competitor and he finds the remains of a tumor, they are exceedingly unhappy. That is the case I never send to the radiologist for treatment; that is the case I want to operate on. We have just heard of one hundred per cent. cures. It doesn't exist. Such a thing absolutely does not exist. Since the war we have had this one hundred per cent. business chewed over and over. There isn't a one hundred per cent. patriot, either. Congress has shown that up. The one hundred per cent. patriot is like the one hundred per cent. cure man; we don't have that sort of thing in medicine.

On the question of dosage, you can put it down so exactly today that it reminds me very much of Apostolli's method, which in the days when I didn't have the money I spent a lot of money for, to treat patients with. During the first year (I only tried it one year, on twelve patients) I tried it, ten were no better and two had died. I have seen some of these patients who suffered a great

deal with radomotor changes afterwards. That doesn't occur where the tumor is removed by surgical means; they don't have that radomotor. You cannot arrange the dose exactly to produce eight months or ten months or twelve months of amenorrhea. You cannot do it, gentlemen. It is in the books and in the papers. I have gone through that all these years, remembering these same assertions.

The secretary of the American College of Surgeons came one time and reported fifty cases of cures by the Apostolli method. I held him up for it a year after. He had to give in. Not a single one was cured, because I went to Chicago to see the patients—and I want to see the patients now. I want to say this, however: that I have seen some wonderful results with deep radiation. Tumors have gone down till you could hardly feel them, until it would take an expert to find them. Nothing would delight me more than to give up the operation for an easier treatment on the patients, the patient always being the first consideration. I have now, however, gone through over one hundred and eighty cases of fibroid tumor operations without losing a single one, and I don't remember that any one of the patients complains of any particular set of bad symptoms. Neither radium nor deep radiation can do any better than that. So I am going to continue in my way unless I have an intelligent woman who is willing to take the chance of a possible operation. We hear of the large tumors. Dr. John Clark very truly said one time: "I hate to make my patient suffer because of the tumor." I think there is something in that.

Dr. J. Roemer, closing: I have nothing to answer to Dr. May's discussion. He practically agrees with everything I have said. As to the treatment of idiopathic hemorrhages by radiating the spleen, that has been tried out by Professor Hulznacht of Vienna in a large series of cases and it was found to be worthless. Uterine bleeding, no matter what its causes, will cease if the ovarian function is suppressed. As to the treatment of those conditions by radium, it can be accomplished, but I don't see any reason why we should subject the patient to a dilatation of the cervix which is already in itself a surgical risk, and at times even anesthesia is necessary to introduce a radium capsule into the uterus. There are also dangers of producing an ulceration, which absolutely cannot happen with the Roentgen ray. With the modern method of Roentgen ray treatment, one does not take any chance, in even the most susceptible patient, of producing injury to the tissues because no more than half of an erythema dose is necessary to be applied to the skin. I agree with Dr. Ill that you have to have intelligent patients that you can reason with.

As to the one hundred per cent. cures, I did not report one hundred per cent. cures; my experience is not so large, but I can say this: That all the cases I have castrated for uterine fibroids or for metrorrhagia, ceased to menstruate and they are clinically cured. As I reported to you before, I have castrated one patient with a fibroid tumor about the size of a six month's pregnancy, about two inches above the umbilicus. It is difficult at present to palpate the tumor. There is only a slight

enlargement of the uterus. The patient has gained about thirty pounds in weight and feels perfectly all right. I have had the same experience in twenty-odd cases that I have castrated for fibroid tumors. I don't know what the subsequent development may be in these cases. I agree with Dr. Ill that these conditions do not undergo malignant degenerations per se. Beclere, of France I think, who is a very reliable and honorable man, whose word can be taken, treated 700 cases and reports ninety-nine per cent. cures. What he means by "cures" is probably the same thing that I have illustrated: Clinical cures.

As to the last remark of Dr. Ill about treating the tumor and killing the patient, I don't think there is any danger whatsoever of that with the modern method of x-ray treatment. With the old technique years ago, of giving the patient a small dose every week for five minutes of soft rays and burning the skin and the underlying tissues, there was danger with the x-ray treatment, as a good many cases subsequently developed malignant diseases due to x-ray burns; but with the present technique of Seitz and Wintz, where thirty-four per cent. of an erythema dose (which can accurately be measured out by means of different instruments, for instance, ionization, by introducing the iontoquantimeter into the vagina or rectum while the patient is being treated), is given to the uterus, there is absolutely no danger of producing any harm to the overlying tissues or to the tissues in the depth.

ENFORCING THE MEDICAL PRACTICE ACT.*

Address of Lawyer Whiteside, delivered at the 158th Annual Meeting of the Medical Society of New Jersey, at Atlantic City, June 6, 1924, as reported by the Stenographer.

By George W. Whiteside,
New York City, N. Y.

Mr. President and members of the Medical Society of New Jersey:

I may possibly have some disadvantage in the fact of my detachment, not being a resident of your State, not being a physician, and not having a direct relation with you as counsel, but on the other hand that may be of some advantage because what I shall say to you, I assure you, cannot have the slightest personal touch with respect to criticism, what I shall say to you will be simply my observations from a detached point of view, without any particular selfish interest with respect to the relation of your Society to the law governing medical practice in this State, or the relation of your Society to the general public with relation to that problem.

The Medical Society of New Jersey represents a profession of learning, com-

prised of persons who have been tested by the State with respect to their moral, intellectual and scientific qualifications.

As such, they are the trustees of the public health and the guardians of the citizens of this community in all health matters. You are leaders, therefore, in the crystallization of public thought on public health matters. You owe to the public as such trustees a definite duty and obligation, primarily, a duty which is far greater than the individual duty that you owe to your individual patient, a duty that you owe to the mass, a duty of instruction in the fundamental elements of medical science that are necessary to the preservation of public health.

The honorable title of "doctor" which is applied to each of you is not a mere empty title, nor a bauble of adornment to satisfy a vain pride. It should be considered in its primary etymological sense—a doctor is primarily a teacher, as the etymology of the word indicates. I think that the public have reason to expect that you will discharge your duty to it first as teachers because it is in that particular branch of the discharge of your obligation that you do the best work in preventive medicine. If you discharge that duty, you are entitled to receive from the public that appreciation which a student naturally shows to the preceptor from whom he has received his learning. You are entitled to receive that co-operation from the public which is essential to the continuance of your work. You are entitled to receive that protection from the law which is necessary to the continuance and the maintenance of the high standards of your profession.

In approaching this subject, let me say that in my judgment the public are only interested in the final product of medical education. The public expects a physician to be well equipped intellectually, morally, scientifically. They do not desire to employ any man that is not so equipped. But the method or means by which that final result is attained is of small consequence to the public. They know little about it and care less. The standards that are set for medical licensure are not standards that are made by the public. These standards have been made high and kept high by the medical profession. The medical profession have constantly placed higher standards to be reached by those who desire licensure; they make it more difficult as time goes on for one to

become a medical doctor, because the profession realizes the necessity of keeping that standard high in order to keep pace with the progress of science, so that the untutored and the unlearned shall not invade and degrade the ranks of a learned profession.

The public recognizes its inability to deal with the problem of keeping these standards up and leaves the matter to you. What, in turn, are you doing to discharge your obligation in that regard? What are you doing to protect the public against the inroads of the quacks who are constantly being licensed in this and other States? What are you doing to prevent your Legislature (which is representative of all the people) from making grave mistakes in breaking down medical standards?

Legislatures are prone to give heed to well-financed propaganda. It is one branch of the Government that I think is more disorderly than any other. I have respect for our Government when I say so. It has been the judicial branch of our Government—and I pay this respect to the profession to which I belong (the judicial branch is presided over by lawyers)—that has done its best to uphold the high standards that the law has set for medical licensure. It has been the legislative department that has done most to break those standards down. The Legislature seems to be responsive not to the reason that appeals to the learned men of your profession, but to the noise and to the clamor and to the excitement of the many, and they lend a most attentive ear to those who have a selfish purpose to serve. They seem to be bent, in many cases, in the granting of these privileges, toward those who do not meet the tests; they seem to convey public rights and public privileges to definite, specific classes, either through their misunderstanding of the problem involved or because of their own particular desire to serve the particular interests for reasons best known to themselves.

This yielding by the Legislature to the noisy clamor on the part of the ignorant and those who seek special privileges, has led to grave abuses and I think those abuses, gentlemen, exist seriously in your State. I will take occasion in a minute to revert to one or two instances in that regard. In other words, I will say this: That licenses to practice healing have by legislative act been granted in barter for

political support or for more tangible and material considerations—and I mean by that, that the Legislatures in the different States are the offenders rather than those who operate under the laws which the Legislatures create.

Why is this so? It is because the public generally does not understand the difference between a medical license and a peddlers license. There are two classes of licenses. Generally licenses are granted to create revenue, and are applied to a particular business that may be affected with a public interest, so as to create certain exercise of police power over that particular business. That is the general class of license.

What is a medical license? It is as different from that as day is from night. I am going to read to you just a few excerpts from Justice Field of the United States Supreme Court with respect to medical licenses:

"Few professions require more careful preparation by one who seeks to enter it than that of medicine * * * A physician must be able to detect readily the presence of disease and prescribe appropriate remedies for its removal * * * The power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequence of ignorance and incapacity as well as of deception and fraud.

"Reliance must be placed upon the assurance of his license issued by an authority competent to judge in that respect that he possesses the requisite qualifications * * * The law intended to secure such skill and learning in the profession of medicine that the community might trust with confidence those receiving a license under the authority of the State."

That is what our highest court has said. That is why I said a few minutes ago that the judicial department of our Government has some adequate conception of what is required in a medical man and for a medical license. Would that our Legislatures might lend an ear to the law that has been laid down by the courts in this regard! Would that they might keep in mind when they make a law for the licensing of those who are to engage in the healing art, that that constitutes a solemn declaration and representation by the State that the person to whom the

license is granted has been tested as to his qualifications and that the result of that test by an agency of the State competent to judge, is that the person receiving that license may be trusted by the community with confidence. That is the legal test for the granting of a license to practice the healing art.

How far away are we from that legal requirement when we examine our own laws?

All you need to do is to examine some of the laws of your own State. I find that last year there was an act passed known as Chapter 161 of the Laws of 1923 and in it (it is supposed to be an amendment to the Limited License Law) is this provision: "* * * provided further that any person who served in the Military or Naval Forces of the United States in the World War and who is now a student or in training in a legally incorporated college of chiropractic under the jurisdiction of the Federal Board of Vocational Training, shall upon being graduated from such institution, and furnishing evidence thereof satisfactory to the Board of Medical Examiners, be entitled to a license under this Act."

No examination and no test is required. How is the State of New Jersey then to certify as to this man's qualifications? The answer is: They are to accept some one else's certification without this State, particularly the certification of a type engaged in the healing art, or the practice of healing that has no scientific basis for its practice. They will accept that and put solemnly the seal of the State upon it and say that because that particular institution has granted this certificate to the man, the State of New Jersey will waive further requirements for certification.

That act is a direct breaking down and destruction of the fundamental requirements for licensure, and I call attention to it because that evil primarily, in my judgment, is at the root of the difficulty in the enforcement of the Medical Practice Act. As soon as you find one type of offender who should be prosecuted and stopped from practicing, he manages to get himself included in an "exception" or an "exemption," and the Act no longer applies to him. It is just as though under the burglarly statute of New Jersey you caught a particular type of burglar, who used a special kind of tool which we will describe as a modification of the old-

fashioned jimmy, and he was prosecuted for burglary; at once, by setting up a cry, he gets the Legislature to exempt from the Statute defining burglary any one who forcibly enters a building with this particular kind of jimmy. (Laughter and applause).

How long would the State of New Jersey be protected against burglars if every year the Legislature did that sort of thing? How long, then, will you be protected or will the public be protected if every year the Legislature puts in some new exception of this kind and grants a special privilege for some reason best known to themselves. The waiver of educational qualifications such as indicated in that particular instance for the practice of healing in any of its departments, whether for the selfish benefit of a particular cult or in mistaken recognition of patriotic service heretofore performed, will be paid for in the loss of human life, and that is a sacrifice too serious to be justified in the name of political expediency or misguided patriotism.

The first great duty in the enforcement of law affecting medical practice by this Society is the preservation, then, of these high educational standards, and that, I think, is the first fight that this Society must make; and you must make your stand, no matter what the class of people, no matter what political power they have, or who seeks the exemption. Having set up these standards of qualification, they should not be avoided or evaded through the process of reciprocity. That is a system by which qualification likewise can be nullified. The law says that reciprocity will be granted where the State has the same or equal standards to this State, and that is a common form of reciprocity in Medical Practice Acts throughout the country.

Well, in one State the standards set by the law may be the same as the standards of this State, but the examination may be very different. So that a man goes up to another State where the law looks just like yours; it looks fine on the surface, but the examination is something that is greased on both sides, and he slips through very readily, and comes into your State by reciprocity. He might never be able to pass the examination in your State. That evil should be stopped. It should be required that every man requesting reciprocity appear before your

Board of Medical Examiners, and he should be questioned with respect to the method by which he obtained his license, and when he obtained it, and the circumstances under which he obtained it, and how long he had been a resident of the particular place—whether he was a bona fide resident or whether he went there for the purpose of getting a Reno decree in medicine.

An examination of the statutes in this State discloses the fact that in medicine, surgery, osteopathy and the limited licenses, the Board of Medical Examiners are required to examine candidates in subjects of anatomy, physiology, chemistry, histology, pathology, bacteriology and hygiene. I don't find anything in the Statute (I haven't found it, if it is there I am ready to be corrected), that makes it mandatory that the examinations be identical. In other words, a man seeking a medical and surgical license may be given a very stiff examination and the fellow looking for some other kind of a license may get an easier one.

I don't know what your practice is. I am a stranger, fortunately, so I am not subject to making any personal remarks or any personal criticisms. As I say, I don't know what the practice is, but that is the way it looks to me under the statute.

Let us imagine that Dr. Eagleton and I both had to be examined in arithmetic before we could come upon this platform, under the law, and the man at the door asked me questions through to long division, but before he let Dr. Eagleton in, he put him through cube root. That is an instance of the inequality that would be permissible under any requirement that we both be examined in the same subject, where the requirement lacks the provision that the examination be the same or identical. Furthermore, for proper enforcement, the grounds for revocation of licenses should be more extensive, because the ethical man who practices his profession is at a great disadvantage in competing with the unethical man. The unethical man may say anything with respect to his claims of skill; he may advertise practically anything, within the law, and attract thereby a clientele. The ethical man, of course, can't do that.

This law should be stiffened up a good deal. We ought to put in provisions there, by which advertising of any kind of treatment that is unscientific would be

grounds for revocation. That is pretty broad. What is "unscientific treatment?" Well, let's leave that to the courts. I will trust them to decide that. If you leave it to the courts to decide what unscientific treatment is, they will call in some very good medical experts to tell whether it is unscientific or not, or will call in some pathologist who may not be a physician, or a bacteriologist who may not be a physician, and you will soon get down to whether or not diphtheria can be cured by pushing one's vertebra; and you will find that the courts will send men to jail who contend that they can cure those diseases in that way.

So that if you have your advertising statute prohibit any form of advertising of treatment that is unscientific, you will reach nine-tenths of the advertising quacks. Furthermore, include what is now in the Statute: advertising to cure chronic or incurable diseases; and include likewise any form of advertising that is deceptive, fraudulent or misleading. You will then greatly improve and strengthen the Statute, and make it more workable.

I find under the Limited License Law what is another fallacy, in my judgment. The Limited License Law, as I see it operate, has a basis for the granting of licenses not primarily educational standards; those are in it, but the theory and basis upon which licenses are granted are that it applies to the particular type of treatment; that is, you differentiate the license according to the treatment.

The most difficult thing in medical practice, in my opinion, is met long before you start treatment. It is met at the very threshold of your relation with the sick—the matter of diagnosis, because there can be only one true diagnosis, though there may be a number of different treatments. When you license one treatment, you are doing so without relation to diagnosis. You cannot base licensure upon treatment without considering likewise diagnosis, and when you make the standard or test what the treatment is to be, rather than also what the diagnosis is, you are proceeding on a false basis.

So that, in my opinion, the classification of your Board, under the law, of the various types of licenses that are granted under the Limited License Act permits you to practice chiropractic, spondylo-

therapy (I didn't know what these were until I read the definitions), electrotherapy, mechanotherapy, neuropathy—all of those are classifications of treatment—suggestive therapy, psychotherapy, magnetic healing. There is no difficulty, if a man meets the primary educational requirements for licensure, to his applying whatever treatment his scientific training indicates, but let us make sure that the fundamental basis for the licensing is educational standards rather than the type of treatment, and we will get rid of nine-tenths of the quacks.

I think until this law is somewhat materially strengthened in that regard, the flood-gates will be open to quackery and open in a more dangerous way than if they were not licensed. In that regard, I wish to take issue with a statement made by one of your officials, I believe—I am not sure whether he is one of your Medical Board; if he is, I differ from him anyway—"That the medical profession should seek to control and not strangle the cults." I think that is a rather attractive form of statement, but very misleading.

There is only one type of control, and that is education of the cults. You can't control ignorance except by education. You can't license ignorance and make it anything else than ignorance. You can't license an unscientific treatment and make it anything but unscientific. (Applause). You could put all the gold seals and red ribbons on it that you please, and sign all the names of the Medical Board with their titles, but you wouldn't change it; it would still be the same thing. That, I think, we have got to get away from. Instead of the statement "control and not strangle," I would say then, "Educate"—and those that won't be educated, strangle. (Laughter and applause).

There is another trouble. The penalties in the law are \$200 fine on first offense, and \$500 for a subsequent offense. That applies to everybody. In other words, the very clever gentleman who fakes the diploma of a deceased physician and fixes himself up so that he may somewhat resemble him and who goes to another community and hangs up the shingle of this deceased physician and starts to practice, falsely impersonating the dead physician, may go on that way for a lifetime without being discovered, if he gets far enough away, down to one end of the State, or away up to the other end. That

gentleman apparently under this Act is subject to a penalty of \$200 if he is caught. He ought to be sent to States Prison.

Now then, the little fellow who perhaps is peddling a few pills, who touches a person and makes a diagnosis of stomach trouble and gives him a few pills, is violating the law and if he is caught he is fined \$200, too.

You cannot, in my judgment, have an adequate or effective enforcement unless your penalties somewhat fit the degree of offence that has been committed. Fraudulently obtaining a diploma is penalized by a \$200 fine—that has to be remedied. Any offence, under this Act, of serious character, should receive serious punishment. For those that are of the minor type, \$200 fine may be enough. But under this Act, a man can continue to pay his fines as often as he is caught, and if he is clever he won't be caught more than once, possibly twice. That is a condition that, in my judgment, needs changing.

Another proposition is that apparently it is not mandatory upon your Medical Board to enforce this Act, and if it were, they probably could say to you, "Well, we are not supplied with the money from the State," which would probably be true. States are niggardly about providing money for the enforcement of these Acts. I should say that the enforcement by the Medical Board should become mandatory, that the Board should be provided with inspectors, because, unless you have inspectors to inspect and discover, you will not unearth offences, and violations. Otherwise you will have to depend upon receiving a complaint here and there. So that there should be adequate inspection and mandatory prosecution.

I submit that you should have a law that has definite prohibitions and which is relieved of many of its present exemptions. There are at the present time twenty-one types of people exempted under the operations of the Medical Practice Act. Reform that. Reform these other evils to which I have alluded. Provide an adequate machinery for its enforcement. Procure a sufficient appropriation to carry it out, and make mandatory the prosecution of offenders by the Board of Medical Examiners. If you will do that, in a short time I believe you will have cleaned up the entire State of New Jersey as far as quackery is concerned.

This, briefly, is a suggested program.

I trust that no one present will think for a minute that I am delivering a lecture or that I am trying to scold anybody. I haven't any such attitude or any such desire, but I do feel that in every State of the Union, including the State of New Jersey, it is necessary to stir the medical profession into greater activity, into greater interest, in order that public support may be gotten behind your leadership, in order that your leadership in these matters may be accepted by the public and acted upon by the public, in order that the Legislators, who are the representatives of all the people, may feel the power of your leadership, and that these various reforms may be brought about and thereby the public interests served and the public health protected.

DIPHTHERIA*

By I. Warner Knight, M. D.,
Woodbury, N. J.

Of all the infectious diseases, we have the most complete knowledge of diphtheria. We know the cause of the disease, a clinical diagnosis can be verified by the laboratory, or the laboratory can clear up the doubts in doubtful clinical cases, we have a specific cure, we know how the disease is transmitted, we can determine which individuals are susceptible and which are immune to diphtheria, we can identify the healthy carriers, we have a definite means of determining when it is safe to terminate isolation, we can prevent the disease in persons exposed to the infection and we can confer a lasting immunity to the disease. Practically the only exact knowledge of diphtheria which appears to be lacking, is how to rid the recovered patient or the healthy carrier of the infection, except by waiting for its disappearance.

Yet, with all this knowledge of diphtheria, the disease prevails and causes more deaths than any other of the so-called diseases of childhood. It is believed that this state of affairs is due chiefly to two things; first, ordinarily the disease does not have an abrupt, severe onset so that often a physician is not called and antitoxin administered until irreparable damage has been done, and second, the general practitioners have not been as active in advocating and administering toxin-antitoxin as that immunizing preparation warrants.

*Read at the Gloucester County Medical Society Meeting on May 22d, 1924, at Westville.

The Klebs-Loeffler bacillus, which is the cause of diphtheria, is one of the few pathogenic bacteria which have been demonstrated to form an exotoxin which permits the production of an antitoxin. That the bacilli are localized in the lesion and the lesion usually where it can be reached by a simple swab, makes it an easy procedure to secure material for diagnostic purposes. In taking specimens for culture purposes care should be taken that the swab does not touch the tongue, as it is quite likely that some bacteria will be picked up from that site, which, in the culture, will overgrow any diphtheria bacilli present and make it impossible for the laboratory men to report more than a contaminated culture. Smears made directly from a throat swab and stained for microscopic diagnosis of diphtheria are not reliable, as the diphtheria bacillus is pliomorphic and may take quite a different form on the culture medium. Even on standard culture media the morphology is so varied that an expert really makes a guess, but with experience he can guess right 95 per cent. of the time, and the clinician can rely upon the report of a good laboratory. Swabs sent to a laboratory should reach the laboratory as promptly as possible, and not be exposed to extremes of temperature on the way, as the bacillus is not resistant to unfavorable environment. The clinician should always bear in mind that a negative laboratory report is never final.

In antitoxin we have a specific remedy for diphtheria and if potent antitoxin is administered in sufficient dosage and early enough, 100 per cent. of cures result. Like all similar biological preparations, antitoxin should be kept at a temperature of less than 50° F. to retain its potency. Just what constitutes a sufficient dose of antitoxin for treatment purposes is not universally agreed upon, but it cannot be too large, and 10,000 units appears to be the smallest advised by those who specialize in the treatment of diphtheria. Within a short time after its administration the greater part of the antitoxin has been destroyed. The important thing is to give enough so that sufficient will be left to neutralize all toxin immediately, for once the toxin has attacked a cell the antitoxin cannot stay its action. Whether the antitoxin should be administered intramuscularly or intravenously, I think depends upon the case and whether the preparation available is one suitable for intravenous use, it being acknowledged that

the quickest results follow intravenous injection.

The diphtheria bacillus is found ordinarily in the discharges of the nose and throat and is transmitted by the transfer of these discharges by contact, droplet infection, in milk, on food, etc. With about 1 per cent. of the population ordinarily healthy carriers, it is frequently impossible to trace a case to an exposure to a preceding case. The number of diphtheria carriers in a community varies. At times, when the disease is prevailing extensively, as high as 5 per cent. may be carriers. Another thing which determines the proportion of carriers is the extent of immunity existing in the community. Other things being equal, a population having high immunity will show more carriers than one with low immunity, as in the latter more of those who contract the infection develop a clinical case.

To detect the healthy carriers cultures made from both the nose and throat are used. To find the carriers the procedure is to culture members of the families in which cases have recently existed, then other known contacts, a school room, an entire school, etc. The search is progressively extended to an ever widening circle from the known foci of infection. In healthy carriers who have been in contact with a case, the infection is nearly always virulent, but the infection found in the carriers from the more widely flung circles is quite likely to be of a nonvirulent type, which can be determined by isolating the organism in pure culture and inoculating animals.

To clear up persistent carriers it is believed there is nothing so good as a normal healthy mucous membrane with its secretions. In these cases the infection is usually too deeply seated to reach with local applications of disinfectants, and if the tonsils are abnormal it may be found necessary to remove them to get rid of the infection. If there is no gross abnormality, then cleansing applications of a non-irritating character, as normal saline solution, seems to be all that is advisable.

The Schick test shows who are susceptible to diphtheria and it is usually used to determine the susceptibles for the purpose of immunizing. Some things which the Schick test has shown are quite interesting. It has shown that if a woman is immune to diphtheria her child will inherit the immunity, but this inherited immunity disappears at about six months of age. During the second six months of life, practically all

are susceptible. As the age increases, an increasing number develop immunity. At what age this will take place or how many will develop this immunity depends upon several things. The first published table showing the percentage of susceptibles at different ages was prepared by the New York City Department of Health. The table (Table I.) was, I believe, developed

TABLE L. Average Susceptibility of Various Ages to Diphtheria as Indicated by a Posi- tive Schick Test.			
Age	N. Y. C'y	No. of Tests	N. J.
Under 3 months.....	15%		
3-6 months	30		
6-12 months	60		
Under 1 year.....		9	55.5%
1-2 years	60	17	100.0
2-3 years	60	20	80.0
3-5 years	40	262	85.8
5-10 years	35	2779	72.9
10-20 years	25	2565	65.3
20-40 years	18		
Over 40 years	12		
20 years and over		190	60.0
(19 Communities) or Groups			
Under 3 months.....	15%	2779	100.9%

from experience with the Schick test in institutions. Shortly after the New Jersey Department of Health began to use the Schick test in population groups, outside of the State Institutions, conditions were found which did not correspond with what it anticipated, its anticipations being based on its previous institutions experience, and this New York City Department table. As our experience has increased we have become convinced that the percentage of susceptibles which exists in a community can only be approximately estimated, and then

only after considering some features of the community itself. In Table II. are shown some of the variations in susceptibility at the same ages in different population groups. Our experience with the Schick test has led us to arrive at the following conclusions:

That the principal factor in determining the extent of the susceptibility which exists in a community appears to be the average daily number of personal contacts (and consequently the opportunities for infection) which are generally experienced by the people of the community.

That the extent of susceptibility existing in different communities varies with the character of the community and of the people living in it.

With regard to the character of the community: 1. That the extent of the susceptibility is greatest in sparsely settled rural communities and decreases as the density of the population increases. 2. That of two communities having an equal density of population, the more extensive susceptibility will be found in that one in which the people are the social, financial and educational superiors of those in the other.

With regard to the character of the people: 1. That the extent of susceptibility is greatest among those people who hold themselves aloof from the crowd, in other words, those of high social, financial and educational standing, and this is not greatly affected by the general character of the community in which they live. 2. That the least extensive susceptibility is found among the people who live in squallor and

TABLE II.
Average Susceptibility of Various Ages to Diphtheria as Indicated by a Positive Schick
Test in Various Communities, or Groups in New Jersey.

Age in Years	An Orphanage	Exclusive Boarding School	Suburban Residential Towns	Manufac- turing Town	Rural Population
1			100.0	100.0	
2	0.0		100.0	60.0	100.0
3	7.7		100.0	90.0	
4	0.0		96.1	66.6	100.0
5	0.0		92.0	74.7	100.0
6	14.8		93.4	56.2	100.0
7	17.1		91.7	52.6	87.5
8	6.4		84.6	50.0	61.4
9	10.0		79.6	55.5	75.0
10	6.9		75.1	54.7	92.3
11	3.1		73.6	55.5	93.3
12	11.1	75.0	72.5	57.1	83.3
13	4.1	90.0	69.2	40.0	95.4
14	0.0	87.7	63.1	33.3	81.8
15	14.2	79.6	59.3		80.0
16	00.0	79.0	52.6	0.0	80.0
17	0.0	77.4	83.3	0.0	84.6
18		69.8	100.0		87.5
19		79.1	100.0		
20-29		85.7	65.3	44.4	
30-39			66.6	75.0	

with insanitary surroundings, and the more densely populated the neighborhood in which they live, the less the susceptibility.

It is believed that, especially in adults, there is often some other effective immunity than the specific antitoxin immunity which protects against diphtheria. This belief is borne out by the observations of McGuire and Hitchens (1) who reported carriers of virulent diphtheria infection to give positive Schick reactions but did not develop clinical symptoms of the infection.

For the prevention of diphtheria we have two preparations, each of which has its particular sphere of usefulness. In antitoxin we have a preparation which confers a passive, immediate immunity. As a preventive, antitoxin is limited, practically, to the protection of persons known to be exposed to the infection. The protection which it affords is temporary and should not be relied upon for longer than two weeks, although in some individuals it will remain protective for some time longer. Positive Schick tests one month after antitoxin administration have been repeatedly observed. With repeated doses of antitoxin its effective period becomes shorter, so that for protection over a considerable period of time antitoxin is not suitable.

In toxin-antitoxin mixture we have a preparation which will give a lasting protection against diphtheria, but it does not confer immunity until several weeks have elapsed after its administration. Toxin-antitoxin in three doses, as it is usually given, does not give immunity in all cases and the Schick test should be used about three months after toxin-antitoxin to determine whether immunity has developed. In different groups from 5 per cent. to 20 per cent. will not respond sufficiently to give a negative Schick test and these should be given another course of treatment with toxin-antitoxin. In this way, practically 100 per cent. immunity can be built up.

Now what can the general practitioner do to help control diphtheria? First, I would say give 1,000 units of antitoxin to all exposed persons, and if the case is not cleared up within two weeks, maintain a careful observation of those in the household to detect developing cases. When considering the immunization of exposed adults bear in mind the adult susceptibility shown in the tables and that three out of forty recently reported cases were in adults. Second, use cultures extensively to detect the mild, atypical cases, to govern the isolation of the patients and the quarantine of

contacts. No diphtheria quarantine should be terminated unless cultures have shown none of the household to be carriers, and for release from isolation or quarantine do not neglect to take nose cultures as well as throat. Some nasal cases are most troublesome as disseminators of infection. Third, and this is the real preventive work, give three injections of toxin-antitoxin to all children after they reach six months and before they are one year old, or, if they have passed this age without having had it, give it to children up to ten years old.

The giving of a Schick test is a somewhat fussy procedure for the busy general practitioner, and besides it requires a little experience before self-confidence is gained, as well as special needles for speedy, accurate work. The Park test which is being advocated to replace the Schick test is, I believe, the test for the general practitioner. While the Park test is probably not so accurate as the Schick test used with a control, its simplicity is in its favor. The Park test is simply giving an injection of the usual 1 c. c. dose of toxin-antitoxin superficially under the skin of the upper arm. This is done with the ordinary hypodermic needle and the reaction of susceptibility is a reddening at the site of injection. The reaction should be examined in not over one week, being at its height about the fifth day. If the individual is immune the dose of toxin-antitoxin does no harm, while if susceptible, but two more injections are called for. The usual method of giving toxin-antitoxin is into the muscles of the upper arm with an ordinary 5/8 inch hypodermic needle. Given deep it does not cause the same degree of local reaction that it does when given superficially for a Park test.

Clinical Reports.

UNCOMMON RECTAL FISTULAE*

Harry Goldman, M.D.,

Attending Proctologist, Hospital for Joint Diseases, New York.

A fistula, connected with or situated near the rectum, is a pathologic condition that necessitates the utmost care in examination, operation and after-treatment to bring the case to a successful termination. Although simple from external appearance, with its one or more innocent-looking openings, only a careful pre-operative examination will avoid embar-

*Read before the Clinical Society of the Hospital for Joint Diseases, March 11, 1924.

rassment from a later discovery that the physician is dealing with one of the uncommon types, a few examples of which follow. Case I and 2 have a rectal connection, and case 3 and 4 simulate rectal fistulae.

Case I.—G. M., 49, single, colored, house cleaner, was referred to my clinic on account of a rectal fistula. He denies venereal infection. Two and a half years ago he began to suffer from constipation, having had one period of 24 days without a movement. He was operated upon at one of our large hospitals for a small fistula that had developed and for the relief of constipation. His condition became worse, and he now has a constant desire to move his bowels, new fistulae have developed and his stool contains pus and blood. On external examination we found a number of fistulous openings leading to the rectum, evidence of operation for fistula posteriorly, and an unhealed wound in the anterior anal region. On rectal examination a number of smooth masses, some with superimposed ulcerations, were found. The rectal caliber is diminished in the middle third. A punched specimen show round-cell infiltration in an inflamed mucosa; no evidence of malignancy. The Wassermann reaction is negative. The pupillary reactions are, however, very sluggish and roentgenography of the tibiae (a diagnostic aid much used in this institution in determining the presence of syphilis) shows an osteoperiostitis. Tenesmus was greatly relieved and the patient gained 24 pounds under anti-leucic treatment. The fistulae are secondary to the luetic affection of the rectum.

Case II.—G. L., storekeeper, referred on account of small fistula that had developed recently near the anal opening. His physician advised him that I might be able to operate in my office and allow him to go home. There was no history of abscess, but he had bleeding from the rectum with unsatisfactory movements. This was considered merely a hemorrhoidal symptom. From external examination the fistulous opening appeared innocent, but on digital examination a cauliflower mass with a crater ulcer was felt on the left lower wall of the rectal ampulla, which on section proved to be adenocarcinoma. The fistula lead directly to the new growth.

Case III.—Mrs. F. L., 38, housewife, came to my office for advise regarding a fistula and for relief from pain in the

coccygeal region. Her rectal history was negative, but last summer she fell on her buttocks while roller skating and since then has had pain which lately has become greatly aggravated, a fistula having meanwhile developed. Methylene blue, injection into the fistula, was not recovered from the rectum and digital examination was negative except for pain when pressing posteriorly. Probing lead directly to roughened bone, an osteomyelitis of the coccyx.

Case IV.—W. S., 17, clerk, was referred to me for fistula operation. At the age of four, he suffered from lumbar Pott's disease and was apparently cured after two years treatment. He enjoyed fair health up to a few months before I saw him, when he began to suffer with constipation, which became more severe in spite of treatment. He awoke one morning with a discharging sinus in the posterior anal region and from that time his constipation was relieved. This, like another case I saw with Dr. Finkelstein at this institution some years ago, was a tuberculous sinus leading to disease in a lumbar vertebra, where the pus, instead of following the psoas fascia, continued behind the anterior vertebral ligaments to its attachment to the sacrum, where it formed a sac, pressing on the rectum and eventually causing obstruction. This was relieved by rupture in the lower portion, finding an exit in the ano-coccygeal line, the external opening of the fistula.

From the above short histories it may be readily be seen that though the symptoms be few, one may be dealing with a grave condition. A complete examination, with the aid of laboratory and roentgenography where necessary, should always be made of every patient with symptoms in the region of the rectum. Furthermore no physical examination is thorough that does not include investigation of the lower intestinal tract.

Pregnancy Following the Ménopause.—Dr. Murray L. Brandt, in the N. Y. M. J., reports the case of a woman, aged forty-six, who had begun to menstruate at thirteen, was always regular, married at eighteen, and since then had eleven pregnancies, resulting in twelve children. The last labor occurred at thirty-nine years of age. Following this labor, she menstruated regularly for a year, last period occurring in June, 1916. In March, 1919, she applied for treatment for an increasing size of her abdomen, increasing weight and intra-abdominal movements. Examination showed a much enlarged pendulous abdomen, funds

of uterus above umbilicus, fetal parts not definitely distinguished and no fetal heart could be heard. Diagnosis of pregnancy was suggested, and, on examination a month later, distinct fetal parts and fetal movements were found.

In May, 1919, she was delivered of a male child weighing nine pounds, and showing all the signs of achondroplasia. Ten months after the birth of the child the patient after weaning the baby, began to menstruate and had three normal periods. The menses have not returned since then. Although pregnancy occurring late in life is not a rare condition, in nearly all the published records of such pregnancies, persistence of menstruation beyond the usual time of the climacteric was noted. Conception taking place after the menopause is a much rarer event. The literature discloses only six (including the above case) authentic cases of pregnancy occurring after the menopause.—Critic and Guide.

Spontaneous Version, Providence Lying-in Hospital

Mrs. E. M.—Aug. 23, 1923.—Gravida ii. Full term. One normal labor. Pelvic measurements normal. Labor began at 7.45 P. M. on August 23, 1923. Examination at 11 P. M. External palpation was very satisfactory because of a flabby, soft abdomen, and revealed a small fetus and a definite occipital posterior position. Fetal heart was heard best in right lower quadrant, low and close to median line. Vaginal examination revealed a vertex presentation, membranes intact, cervix thinned out, and external os about three fingers dilated.

One hour later, marked bulging of the perineum was reported and preparation for immediate delivery were made. First to appear through the vulva were the unruptured membranes, which were punctured, and a left hand protruded into the outside world. The uterine contractions were very strong and in about five or six pains the left arm, left shoulder, left chest, left abdomen, left buttock and right buttock appeared in succession at two or three minute intervals. During this procedure the operator's finger was kept in the interspace over the fetal heart and no interference with the fetal circulation was noted until the buttock had appeared when the right shoulder and head were rapidly extracted. Child was cyanotic and was resuscitated without difficulty. Weight, 4 lbs. 14 oz.

Dr. Lee states that spontaneous version is not infrequent in transverse positions with large pelves and small children, but this case was a vertex presentation, both by external palpation and vaginal examination.—Earl A. Bowen, M. D.

Uterine Fibroma Weighing Forty-seven Pounds

Dr. M. Y. Marshall, Henderson, Ky., reports the following case in the Kentucky Journal:

The patient, a negro woman 50 years old, was operated by Dr. J. C. Mosely and myself at The Moseley Hospital, this city, about two weeks ago.

The tumor, which was first noticed about 15 years ago, was enormous, filling the entire abdomen to the ensiform, and considerably larger than a full term pregnancy. The omentum was adherent to the upper surface of the

growth and the omental veins tortuous and dilated to 1-2 or 3-4 inches in diameter. There were no other adhesions present, and the operation presented no especial difficulties. The growth was sessile on the uterine fundus, and joined to the latter by a very short peduncle, oval in crosssection, and about 2x3 inches.

The weight of the tumor was 47 pounds and on sectioning it, two areas of necrosis and cystic degeneration were found in the center of the growth. But for these areas it presented the typical appearance of a fibromyoma. The post operative history, has been entirely uneventful up to the present time.

Pernicious Vomiting of Pregnancy Treated With Glucose and Insulin.—Dr. Raleigh Andrews, of St. Louis, reports this case.

Patient, married woman, age 18. Admitted to hospital January 26 with history of vomiting. Family and past histories unimportant.

Menstrual History.—Patient began at 13 years, 28 day periods, no irregularities, slight cramping at beginning of period.

Marital.—Married at 15 years. First pregnancy accompanied by great deal of nausea and vomiting with miscarriage at 4 to 5 months. Present illness began with vomiting about December 26, 1923. Last menstruation November 22, 1923. Since first week in January patient had had constant nausea and vomiting, retained practically no food and no fluids excepting water week preceding admission to hospital; even water was vomited containing considerable bile.

Course in Hospital.—Admitted January 26, with marked dehydration. Blood pressure 120/70, pulse 114, temperature ranging from 97 to 99. General physical essentially negative. Blood count 8,300. Hemoglobin 73 per cent. Red blood count 4,300,000. Urine showing faint trace albumin, specific gravity 1.028 with diacetic and acetone positive, occasional granular cast. Patient taken off all foods by mouth, given normal salt solution subcutaneously, 200 cc. of 3 per cent. glucose and 2 per cent. sodium citrate per rectum every four hours. The subcutaneous fluids were discontinued after the second day. She was allowed sips of water by mouth and liquid food after the fourth day, but vomiting continued to the time patient was seen in consultation February 6. At this time nasal tube was inserted and 800 cc. of carbohydrate fluid was given through the tube and 500 cc. of 20 per cent. glucose given intravenously. The following night she excreted 33 grams, diacetic acid and acetone. There was still some vomiting and nausea. Until February 7 she was given 270 cc. carbohydrate fluids through the tube, also 700 cc. of 50 per cent. karo syrup and 1,000 cc. of 20 per cent. glucose intravenously. During the 12 hours she was given 80 units of insulin. The day urine with the insulin showed 20 grams sugar to the 1,000 cc. Night urine showed 16 grams to the 1,000 cc. On February 8 vomiting and nausea had entirely ceased and she was given food by mouth. With the cessation of high sugar intake the urine contained only a trace of sugar, no diacetic acid and a trace of acetone. No further insulin was given. The patient continued to improve although a distaste for food

persisted. No vomiting occurred. She was allowed up in a rocking chair on February 14 and was to be discharged the next day when she aborted.

The case is of interest from the fact that these patients when placed on a high carbohydrate intake, which is essential, spill over sugar in the urine from their low renal threshold and that this carbohydrate can be utilized if insulin is given intelligently. The fasting blood sugar before insulin was given and while she was getting a moderate carbohydrate intake and showing sugar in the urine was .12 per cent. After 80 units of insulin during the day and excessive carbohydrate intake her blood sugar was .09 per cent.

Case of Unusual Susceptibility to Iodin.

Dr. H. E. Happel, St. Louis, reports the following case in the A. M. A. Journal:

A white married woman, aged 50, admitted to the hospital, Feb. 8, 1921, suffering from metrorrhagia due to a fibroid uterus, was operated on, next day. In the course of a supravaginal hysterectomy, after dividing the uterus at the level of the internal os, I attempted to cauterize the cervical canal with phenol and alcohol; but the quantity at hand was insufficient, and I took a cotton-tipped applicator, dipped it into tincture of iodine, and touched it to the cervical stump. Less than a drop of the tincture was used. Seventeen hours later, about 4 A. M., the patient began to complain of an intense itching and burning of the skin, with a sensation of swelling of the face and hands. When the light was turned on and she saw wheals on her arms and hands, she exclaimed, "They used iodine on me." The nurse examined the abdomen and found that picric acid solution had been used in preparation of the skin, and so informed her; but she insisted that iodine had been used somewhere, stating that about nine years before she had had a similar experience after painting the back of her neck with iodine to relieve soreness of the muscles.

The rash was a typical urticaria involving the face, scalp, upper extremities, trunk, and to a less degree the lower limbs. The intramuscular injection of 10 minims of epinephrin chlorid, 1:1,000 solution, gave almost instant relief, the rash disappearing as if by magic; but it reappeared in about four hours. A second hypodermic of epinephrin produced the same effect, though not so promptly. The attack lasted two days, and the eruption was readily controlled by epinephrin. The attack nine years before lasted one month. Less than one drop of iodine was used, and the patient was almost frantic from the itching and burning of the skin. I hesitate to think what might have happened if her abdomen had been painted with iodine instead of the 5 per cent. alcoholic solution of picric acid.

New Gastro-Intestinal Procedure.—Dr. A. L. Soresi, N. Y. City, will hold a scientific meeting at his Laboratory of Surgical Research, 511 East 63rd Street, on Wednesday, August 27th, at 2 o'clock P. M. The topics to be presented and discussed are: 1. The Comparative Value of the Different Methods of Intestinal Anastomosis; 2. Oblique Gastro-Jejunostomy; 3. Umbilical Artificial Anus. Physicians are invited to attend.

Society Reports

WARREN COUNTY.

F. A. Shimer, M.D., Reporter.

A meeting of the Warren County Medical Society and the Warren Hospital Staff was held at the Warren Hospital, Friday noon, June 27, which included a luncheon and inspection of the building, with a good sized attendance, in spite of the inclement weather. All expressed general satisfaction and approval of the building. Dr. Paul R. Correll, the principal speaker and guest, took for his topic, "Co-operation." Superintendent Dr. Lewis of the Eastern Hospital spoke on the hospital work in general.

Warren Hospital is a new sixty-bed hospital located in Phillipsburg, the money to build and equip the institution was partly raised by public subscription.

A. M. A. PROHIBITION.

Without a dissenting vote, the House of Delegates of the American Medical Association adopted last week a resolution calling on the Board of Trustees to use its best endeavors to have repealed such sections of the national prohibition acts as may interfere with the proper relation between the physician and his patient in prescribing alcohol medicinally. The resolution has been greeted by the press of the country with general approval. Most of the Chicago newspapers have already expressed themselves editorially, and the following statements represent their general attitude:

Physicians who object to the provisions of the Volstead act regulating the use of alcohol in the practice of medicine are unanswerable. If the law allows a physician to prescribe spirits for a patient, as it does, the dosage is entirely a matter for the physician's judgment and not for congress to prescribe.

The law adopts a principle which makes congress the doctor. The arbitrary dictum is that a patient may be given a pint of whiskey every ten days as medicine, but no more, regardless of the opinion of the doctor in the case.

Congress might have declared that whiskey had no medicinal value. Some physicians hold that it has no peculiar medical value. Others contend that it has. In practice they can follow their own opinions. They will all agree that if it has value the doctor who prescribes it at his own discretion should have discretion as to the amount.

Congress went on the assumption that the medical profession would misuse the prescription blanks. The dregs decided that the person who violated the intent of the law and got whiskey as a beverage because it was legalized as a medicine should have just as little satisfaction out of it as possible. Of course they did not reach the man they intended to reach. The unscrupulous physician has no difficulty with this limitation. He has many expedients by which it can be avoided. The scrupulous physician finds that his practice is controlled by a law which affronts both his intelligence and his honesty.

It is an absurd theory that congress may substitute itself for the physician in the treatment of disease, and it is no wonder that many physicians resent such an ignorant and dictatorial interference with medical practice.—*Chicago Tribune*.

The eighteenth amendment is directed solely against the use of liquor as a beverage, and whether the medical clauses of the Volstead law are valid is a question not yet dealt with by the Federal Supreme Court.

Some physicians, it is true, yield to the temptation to prescribe liquor where it is unnecessary, and not a few have permitted themselves to become bootleggers in disguise. But Volsteadism, with its sequels and supplements, has not prevented unscrupulous abuses and never will entirely prevent them. The medical profession should purge itself of immoral and dishonorable elements, and its efforts in that direction would be stimulated by a congressional policy of confidence toward it. The honorable physician is hampered by Volsteadism, while the charlatan is not even inconvenienced.

The modification of the prohibition statutes demanded

by the medical profession would not obstruct proper enforcement of national prohibition. On the contrary, it would tend to facilitate enforcement.—*Chicago News.*

It has long been recognized that legislation is just likely to follow public emotion as it is to be guided by scientific knowledge. This fact was excellently expressed by Chief Justice Oliver Wendell Holmes in "the Common Law," when he said:

The life of the law has not been logic; it has been experience. The felt necessities of time, the prevalent moral and political theories; institutions of public policy, even the prejudices which judges share with their fellow men have had a good deal more to do than the syllogism in determining the rule by which men should be governed.

The action of the House of Delegates and the general approval given it by the public as expressed through the press are indications of a healthful reaction against enactments and regulations which have recognized, in their formulation, popular, prejudice rather than scientific fact.—A. M. A. Jour.

Miscellaneous Items

Medical College of the University of Maryland.—Several New Jersey young men graduated from this college last month. Marcus H. Greifinger of Newark received one of the six certificates of honor. Other graduates from Essex County were: Nicholas A. Antonius, Orange; Ira I. Flax and Ralph N. Shapiro, Newark; also Leo Schlenger of Paterson.

Solving Rural Doctor Problem.

Physicians are not always appreciated, but one who lives at Shamrock, Mo., recently announced he would have to leave the community because he wasn't getting enough money to survive. The community at once showed its appreciation by raising \$1,000 in money and told him to double his rates and remain. Most communities show their appreciation of doctors by making them wait until they pay all others.—Sturgeon (Mo.) Leader.

Value of Expert Testimony. Protest of a Layman.

To the Editor of The Boston Herald:

A Massachusetts psychiatrist sets forth to Chicago to examine the boy murderers, Loeb and Leopold, and forthwith his name and mission emblazon the front pages of newspapers throughout the land. Fifty more hand-picked experts in psychiatric practice, the world is informed, are engaged to uncover some physical or physiological basis for the contention that the murderers of the boy Franks are insane. Fifty! A formidable army of workers, indeed.

To what end, this gathering up from near and far of specialists? The average citizen sees in this sort of thing a sinister omen: A desperate effort to save these scions of notable families from the consequences of their crime, and to impress and embarrass the minds of jurymen with the latest fantastic theories regarding human conduct, crime, responsibility and moral attitudes.

Doubtless, fifty equally prominent psychiatrists may, and probably will be, engaged by the State to "show up" errors and inconsis-

encies in diagnosis of the defense experts; and the long-suffering public is due for another unedifying spectacle like unto the Thaw trial when serried ranks of medical experts battled furiously—in the cause of their retainers.

The memory of that event in medical history still remains as a stench in our nostrils.

The spectacle of a contest of this kind is not a pleasing one. It is one in which the mental expert has become a prominent and most offensive figure. Massachusetts, within its own borders, has made such exhibitions impossible by a statute governing the examination of criminals by experts, appointed by the Commission on Mental Diseases, whose impartial findings are rendered to the court. Is there no present remedy for the evil-appearing sort of thing that seems about to be staged in connection with this case: This contest of wits and casuistry between hired experts, for so it appears to the average layman?

Where stands the great American Psychiatric Association on this question? And is it not about time for that organization to apply a moral medicine to this mortifying mischief.

Amos B. Tucker.

Taunton, June 16.

Mortality of Insured Infants.—The Metropolitan Life Insurance Company began in the spring of 1923 to insure the lives of children under 1 year of age, and during the year, about 519,000 such policies were issued. The death rate was extraordinarily low, considering that these children were drawn from the wage-earning group. There were 34.5 deaths per thousand lives exposed to risk under 1 year of age. For the age division 9 months and under 1 year, the infant mortality rate among insured children was approximately the same as that which has prevailed among babies in the birth registration area of the United States. It should be remembered that these policies for infants were effected only on healthy lives. The mortality experience, therefore, does not include the great number of children born with congenital defects or affected with obvious developmental defects or acute diseases and conditions at the time of insurance.

Request for Cases of Hemophilia and Other Hemorrhagic Conditions.

By a method which seems absolutely safe, on experimental animals, we have succeeded in reducing the coagulation time of the blood from an average of eight to ten minutes to an average of one minute and a few seconds. It appears logical that the coagulation time can also be reduced by this new method in cases where the blood has little tendency to clot and capillary oozing cannot be stopped by the usual means, such as hemophilia and other hemorrhagic conditions—the marked reduction of the coagulation time would therefore check hemorrhage in these cases.

We will be glad to offer this new therapeutic means to colleagues having patients suffering from uncontrollable hemorrhagic conditions. No financial compensation is sought; this offer is made under strictly ethical conditions. For further information address, Flower Hospital or Dr. A. L. Soresi, 58 West 58th Street, New York City. Telephone No. Plaza 7439.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

CHAS. D. BENNETT, M. D., Chm., 750 Broad Street, Newark.

EDITOR:

DAVID C. ENGLISH, M.D.,
P. O. Box 83, New Brunswick

ASSOCIATE EDITORS:

CHRISTOPHER C. BELING, M.D., Newark
HENRY B. COSTILL, M.D., Trenton
JAMES HUNTER, JR., M.D., Westville
HARRISON S. MARTLAND, M.D., Newark
FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

OUR NEW LEADER.

We are glad to welcome Dr. Lucius F. Donohoe as our Acting President this year. We are sure of advance in our Society's prosperity under his administration from his splendid record as president of the Hudson County Society.

OUR OFFICERS' VACATIONS.

Dr. Lucius F. Donohoe, 33 Dodge Street, Bayonne, Acting President, will go to his camp at Moosehead Lake, Maine, about the middle of August for about two weeks.

Dr. J. Bennett Morrison, Secretary, is at 51 A. Oak Street, Portland, Maine, and will return September 2d.

Dr. Elias J. Marsh, Treasurer, is at home, 400 Van Houten Street, Paterson.

Dr. David C. English, Editor of Journal, is at the Elms Inn, Harrison, Maine; will return August 15th.

Dr. Charles D. Bennett, Chairman of the Publication Committee, has returned from Maine. Office, 750 Broad Street, Newark.

LAWYER WHITESIDE'S ADDRESS.

We have inserted Lawyer Whiteside's excellent address, on "Enforcing the Medical Practice Act," in this issue of our Journal, because it has a practical bearing on the work of our Society, through the Welfare Committee especially, and it is desirable that our members generally shall read and carefully consider its suggestions before we enter upon our fall and winter's work, as related to our legislative activities. Mr. Whiteside is the counsel of the New York State Medical Society and has rendered that Society most valuable service the past few years. He has also helped our Welfare Committee the past year solve some of its problems.

PUBLICATION COMMITTEE RULES

The Editor again calls attention to the following rules of the Publication Committee: All State Societies' Journals or other Journals; all reading matter for insertion in the Journal and all correspondence with the Editor should be sent to New Brunswick—not to Orange. All matter for our advertisement columns; notices of our members change of residence or office, and all notices of failure to receive the Journal, should be sent to Dr. C. D. Bennett, 750 Broad St., Newark. Notices of change of residence or office should also be sent to our Secretary, Dr. J. B. Morrison, 97 Halsey St., Newark, for insertion in our Official List. Careful observance of these rules will save these officers much time and labor, and save the Society considerable expense.

ALL MUST BE SERVED.

In this day of excitement, of restlessness, of dissatisfaction, of grasping for the luxuries of life, the medical profession must exercise extraordinary care that the general trend of the times does not draw it into the whirlpool of desires to the debasement of its time honored and time respected ideals and convert its professional idealism into business acumen and trade union selfishness. Respect for self and respect for our profession demand that our service be adequately recomposed, but we must be ever mindful that the fees which we exact should also be commensurate with our patient's ability to bear financial burden, and that the overburdening of the patient with professional charge is a large factor in driving a proportion of our population

into the care of clinics and welfare associations, to the patients' degradation as being dependents, the doctor's disgrace as being grasping, and the profession's reproach as debasing its high ideals. More and more is the practice of medicine invaded by governmental, social and welfare organizations, to the ultimate harm, as we believe, not only of the profession but also the people, and commercialism on the part of the individual doctor will promote that movement which we recognize as a menace. It must not be truthfully said that only the very rich and the very poor can receive adequate medical care.—G. E. Follansbee, in the *Ohio State Medical Journal*.

MEDICAL DISEASES: PNEUMONIA.

Pneumonia is frequently called by surgeons "a medical disease" and of course the illness as such allows of no surgical interference. The designation as "a medical disease" is distinctly inept not only because surgical complications may arise in the course of the disease due to the pneumococcus or other offending organism, and because of the frequent occurrence of pneumonia after operation, but also because of the difficulty that arises in differential diagnosis of abdominal surgical conditions and pneumonia at their onset.

Empyema, lung abscess, peritonitis, otitis media, arthritis, parotitis, and metastatic abscesses may demand the attention of the surgeon. The frequency of discovery of postoperative pneumonia depends largely upon the assiduity and the frequency with which the patient is examined after operation. It is extremely common though it may be quite transient and not severe.

The most interesting relation is in differential diagnosis. It is in the experience of many surgeons to have operated upon a case for what was considered appendicitis that proved to be referred pleuritic pain heralding the approach of a pneumonia. In this type of case the appendix is normal or at most the seat of old scars. The patient in whom the mistake is made is usually a child, occasionally an adult. Children almost never, but adults frequently are affected with postoperative pneumonia, which fact is an important point in differential diagnosis. If, after an operation for supposed appendicitis, the child shows signs of pneumonia, we may with great surety say it

is a pneumonia independent of operation and that the pain was due to the referred pleural irritation. But if an adult who is operated upon under the same conditions, with negative findings, develops pneumonia, one must assume that the condition is that of postoperative, not primary pneumonia.

This subject is at least suggestive of the fact that the expression "a medical disease" as applied to pneumonia (and some other conditions also) is a misnomer. It should further suggest that the surgeon who can employ a stethoscope with accuracy, far from losing his prestige in surgical circles becomes an infinitely better surgeon and distinguishes himself from the mere technician.—J. B. S., *Amer. Jour. Surg.*

THE NEED.

One newspaper is quoted as stating that the most important happening in this country last year was the birth of 2,000,000 children.

How many of them lived? This is not known accurately, because there remain eighteen states whose registration of births is so incomplete as to exclude them from the birth registration area. Of the thirty states in this country within the registration area, one child in every thirteen born dies during its first year. If the same ratio applies to the states whose birth registration is incomplete we have a total loss of 190,000 American children a year.

That is startling, but it is a long way from the day when parents were considered fortunate if they were able to bring up two out of every three of their children. Still, it leaves us behind five other nations, including New Zealand, the best off of all countries which keep books on their greatest asset, which loses only in twenty of its children during the first year.—*American Child Health Association*.

Intestinal Resection on the Wane.—Resection of some portion of the intestinal tract, whether of the cecum alone or of the whole colon, is tending to have a more and more limited field; like many other surgeons, I find that I am performing this operation very infrequently. In my opinion, it should be limited to extreme cases in which the colon is not only low, but also very atonic. It is an operation which is associated with a considerable mortality, and therefore it will not often be justified as a form of treatment for a condition which, although very disabling, does not in itself lead to the death of the patient.—A. J. Walton: *Lancet*.

BOARD OF TRUSTEES MEETING.

The Board met in the rooms of the Academy of Medicine of Northern New Jersey, July 2, 1924, Dr. Sproul presiding with 14 members present.

The Secretary presented the following letter: My dear Dr. Morrison:—I beg to acknowledge the receipt of your letter of June the ninth, notifying me of my election as President of the Medical Society of New Jersey at its Annual Meeting in Atlantic City, June 5th to 7th. I am not unmindful of the great honor conferred upon me by this action of the Society with which I have been actively connected for thirty years as its Treasurer.

I am deeply moved by this expression of confidence and good will on the part of the Society. I am, however, forced to the conclusion, after careful and mature consideration, that at my age and with somewhat impaired health—as the welfare of the Society must be the first consideration—I cannot regard it as wise for me to assume the responsibilities and burdens of the office. It is therefore with the most profound and sincere regret that I feel myself forced to resign the office.

Very truly yours,

Archibald Mercer.

The Secretary of the Society and Editor of the Journal stated the result of conferences with Dr. Mercer since his resignation was received, that he would not reconsider it.

The resignation was accepted with expressions of deep regret by all the members present. According to the provisions of the Constitution and By-Laws, First Vice-President Donohue was declared to be Acting President of the Society.

The following resolution was unanimously adopted:

Resolved, That the Board of Trustees instruct the Committee on Publication and the Committee on Programme and Arrangements that after the expiration of the present contracts, they are not to publish in the Journal, or in the Official Program, or allow to occupy space in Exhibit any advertising matter from Indemnity Insurance Companies in competition with the United States Fidelity and Guarantee Company, with which company we carry our contract for Group Insurance.

WELFARE COMMITTEE MEETING.

A special meeting of the new Welfare Committee was held at the Essex Club room July 7th. At the request of President Donohue a temporary organization was agreed upon and Dr. Andrew F. McBride was elected temporary chairman and Dr. F. J. Quigley temporary secretary.

Dr. Eagleton brought up matters that should receive early consideration as follows: Medical Expert Testimony; Medical Practice Act Amendments as suggested by Mr. Whiteside; Full-time Executive Secretary; Post-Graduate Instruction.

Case was considered under Workman's Compensation Act, of injured workman sent to hospital by employer and a doctor for the insurance carrier of the employer later ordered treatment by the attending surgeon discontinued. A resolution was adopted that the Welfare Committee, acting for the Medical Society of New Jersey, depreciate this prac-

tice from the standpoint of ethics, treatment and rights and give a remonstrance with the Workman's Compensation Court having this case under consideration, calling attention to the illegality of this action.

FOR WHOM SHALL WE VOTE?

We take the following from the Texas State Journal of Medicine and ask our readers to give it careful consideration as it applies as well to our own State.—Editor.

It seems to us that the doctor has a double civic duty in the field of politics. He is interested, as all good citizens should be, in all problems which pertain to government, in addition to which he has peculiar and almost exclusive knowledge of medical and public health matters, than which there are no question of more importance to state and municipal governments. It is unfortunate that the doctor has so largely assumed an air of indifference, if not superiority, to all things political. We can account for his failure to fully discharge his political obligations only on the ground of preoccupation or fear of offending. In this connection, we might point to the fact that those who would be offended because the doctor pronounces himself on public health and medical questions, would not be his friends anyway. He really has nothing to lose. No good citizen can afford to be too busy to vote, and vote right. Indeed, he should feel it his privilege and his burden to spread the gospel of good government, as he sees it, whenever opportunity offers.

The present political situation is of extreme importance. The question of public health is before the public. The people are being told that we would have them take charge of health matters, and that they should see that only those candidates for office in the legislative, executive and judicial branches of the government, are elected, who are interested in such problems and who will view them in a sensible, orthodox manner. If at this time the medical profession is not active in pointing the way, the public will assume that our activities are perfunctory and our talk just ordinary propaganda. We may vote our convictions when the time comes, but our vote is of less importance than our influence properly exerted. No one ever accomplishes a great deal by merely voting.

Just now, the enemies of beneficial medicine and public health legislation are displaying unusual activities. It is not practicable to discuss these activities at this time. Perhaps it will be sufficient to quote the following questionnaire, put out by the chiropractors, evidently to all candidates for the Legislature, and for other offices that count:

"Believing, as we think you do, that the public is entitled to know the opinion of all those seeking public office, on matters of public concern, we are submitting to you as a candidate for State Senator of the great State of Texas, questions for your consideration as a matter of vital concern and that will be a 'live' issue at the next session of the Texas Legislature. We feel that we shall receive a frank reply to same:

"1. Do you believe in the science of chiropractic?

"2. Would you favor a law regulating the

practice of chiropractic; one that protects the public and restricts the chiropractor to the practice of their profession and does not infringe upon any other profession?

"3. Would you favor a law with standards equal to those of twenty-seven other states that have already made chiropractic legal?

"4. Would you favor a law that gave to the chiropractic profession their own board of examiners; said board to be composed exclusively of chiropractors and be maintained by the State from fees and dues collected from the chiropractic profession and applicants to practice?"

Of course, it is all perfectly silly and has the earmarks of being an amateur effort. It does not sound like the astute politician whom we have understood is in charge of the legislative interests of this particular group of offenders against our Medical Practice Act and the good health of our people. There is either a trick in it, or else the chiropractors are trying to play the political game without the expert advice they usually have.

The Council on Legislation and Public Instruction has endeavored to ascertain the views on public health problems of those candidates for office in whom the medical profession may be interested on a statewide basis. County society legislative committees must be depended upon to determine the views of candidates for the Legislature. The following propositions have been used by the Council—it is suggested that they be used by county societies (contrast them with the chiropractors' questionnaire):

"1. Revision of the public health laws, to the end that the Health Department may operate efficiently and economically. It is felt at this time that the most sensible way to bring about this condition of affairs is to provide for a Board of Health with interlocking terms of office and sufficient power to control health conditions, the State Health Officer to be an employee of the Board.

"2. Adequate provision for the care and treatment of our insane. It is believed that if a law may be devised which will provide for a psychopathic hospital, for the observation, diagnosis and treatment of those believed to be insane, to which commitment may be both on a volunteer and compulsory basis, many otherwise hopelessly insane may be returned to useful and safe citizenship, the residue going to the so-called insane asylums for incarceration and humane care.

"3. Maintenance of the present system of a single standard of educational requirements for all who would practice medicine, no matter after what so-called school or system of practice, is considered a public health problem of supreme importance. An effort will doubtless be made to secure separate boards for those who disagree with the facts of science as pertain to the practice of medicine. Such a system is held by us to be not only dangerous to the public health but unconstitutional as well. It is an imposition on the medical profession to require constant contention against serious efforts of this sort. The medical profession cannot evade the issue and stand from under the responsibility of protecting the public against un wisdom of this sort."

Those who react in an unsatisfactory manner when approached along these lines should

be opposed. It should be borne in mind that the record of those who have heretofore been in the Legislature and the attitude of as many as we have been able to get an expression from, who are now candidates, are on file with the State Secretary, and will be immediately available upon request by letter, telephone or telegraph. Legislators who voted for the final passage of the Medical Practice Act amendment last year claim to have helped pass that law. Such is not the case altogether. If a legislator voted to exempt chiropractors or christian scientists from the law, he was against it, no matter whether he subsequently voted for it or not. The view of the Legislative Council on certain candidates for state office, as heretofore promised, follows:

How the Candidates Stand.—The Council on Legislation and Public Instruction authorizes the publication of the following, relating to the attitude of those candidates for office in whom the medical profession should be interested on a statewide basis:

For Governor.—Each candidate for Governor received a letter from the Council, requesting his attitude on the three points mentioned in the preceding editorial, with the following results:

General Thomas D. Barton of Austin, the present Adjutant General, replied very satisfactorily. We quote three paragraphs from his letter.

"There is no department of the State government which is more closely connected with the welfare of Texas people than the State Health Department, and no department should be further removed from political disturbance, yet it is well known that such has not been the case in the past. The plan proposed by your Association providing for a Board of Health, to be composed of the most able medical men to be found in the State, serving with interlocking terms of office and having authority to fix public health policies of the State and to employ the State Health Officer, would, I believe, go far toward removing the Health Department from politics.

"About the only class of institutions in the State which never has a lobby to take care of its interests are the eleemosynary institutions. No one interests himself in the condition of the Insane Asylums, the School for the Blind, Deaf and Dumb, the Epileptic Colony, the Tuberculosis Sanatorium, the Feeble-minded, etc. The condition of the insane in Texas is nothing short of a crime. Almost every jail in Texas has some of these poor unfortunates, being held for someone to die to make room for more. I promise you that if I am elected your Governor this condition will be relieved, or there will be no appropriation for any other purpose signed. I will do the lobbying for the Eleemosynary Institutions myself. This is one debt the State owes and cannot dodge, and it shall be paid if I am elected your Governor.

"In the matter of the public health, I stand committed to the unqualified observance of the principles laid down in scientifically proven medicine. Theories do not appeal to me in the face of proven facts. I believe thoroughly in an educated medical profession, in the matter of private practice, and in the prevention of disease. It is my conviction that those who would assume the serious responsibility of prac-

ting medicine should be thoroughly educated in the basic facts of medicine. I do not consider it the business of the State to determine how the individual shall make application of the knowledge thus gained, or under what banner he shall march in the parade. I shall look upon the legalized medical profession of this State much as a student would look upon his library; as an institution to be consulted and considered at all times, and followed when the advice thus gained appears to be wise."

Senator Joe Burkett of Eastland, failed to reply directly to our letter. However, his county medical society officially endorsed him, and his record in both House and the Senate has heretofore been highly satisfactory, so far as it relates to medical and public health matters. Indeed, he was generally accounted the staunch friend of standardized medicine and practical public health. His record as District Judge, before his election to the Legislature, was satisfactory. His medical friends are enthusiastically supporting him.

Honorable V. A. Collins of Dallas, did not reply to our letter, neither did he reply to letters from other sources, which were inspired by us. We feel that we have made every reasonable endeavor to ascertain his views, and that his silence gives consent to the rumor that he is not favorable to the contentions of the medical profession in the interest of the public health.

(The result of the attitude of candidates for the Legislature follow these replies.—Editor.)

Typhoid Precautions.

From the N. Y. Tribune.

The danger of drinking from springs and brooks has had emphatic illustration in the typhoid fever outbreak traced to a small stream on the Palisades near Englewood. The Health Commissioner of this state, in consequence, has taken the wise precaution of inspecting all sources of water supply in the Palisades Interstate Park. The result thus far is instructive. Analysis of the water of forty springs has shown that five of them are polluted. There is plenty of chance for an epidemic of "summer typhoid" if campers and picnickers do not boil their drinking water. Few of them are likely to go to that trouble. Some will not pay attention even to specific warnings. In spite of typhoid signs posted at the Englewood brook, the police patrol is busy keeping visitors from drinking there. It is hard to educate a great many persons in sanitary caution when the peril is not perfectly obvious.

The local Health Department has given sound advice to all likely to be exposed to typhoid infection to have themselves inoculated with anti-typhoid serum. The experience of the army has proved on an enormous scale the value of this preventive. It confers immunity. Yet doubting individuals and organizations are doing the poor service of attempting to dissuade people from protecting themselves against typhoid by this means. If they had their way the country would still be cursed with smallpox and every disease controllable by vaccination would swell the death rate.

HOSPITAL REPORTS.

Bayonne Hospital.—Drs. W. A. Pinkerton and Jos. Krobalski report these two cases of Botulism treated in the Bayonne Hospital:

On December 30, 1923, Mr. L. and Mrs. H. had dinner at the home of a friend in Plainfield, N. J. There were ten people at that dinner, three being children. The dinner consisted of fresh chicken, soup, Jell-O, canned squash and ice cream. Everyone partook of all the ingredients of the dinner except the squash, which was eaten by only four of the party. Among those four were the two patients and a sister of the female patient. The sister, who resides in New York City, had only very few and mild symptoms according to her physician. On Dec. 31st, the patients began to have malaise, and loss of appetite. That day they had nothing to eat but freshly made soup. The woman became quite ill that night with vomiting and diarrhea. On Jan. 1st., 1924, the man also began to vomit and that day both patients complained of weakness, diplopia, blurred vision and vertigo. They were under the care of their family physician until Jan. 3rd, when they were advised to go to the hospital for observation and treatment.

On admission the patients were obstinately constipated but had no vomiting. They complained of weakness, diplopia, difficulty in speech and inability to swallow. The mucous membranes of the mouth and throat were dry and there was a nasal sound to the voice. When the patients attempted to swallow, they became cyanosed and the fluid regurgitated through the nose. The pupils were dilated and reacted sluggishly. The man's temperature was subnormal, 97°F., while the woman's was slight above normal, 101.4°F. The pulse and respiration were increased in both cases. Urinalysis showed traces of albumin and fine hyaline casts. The urine was cloudy and of higher specific gravity than normal. The blood count showed a decreased number of erythrocytes and an increased number of leucocytes. The polymorphonuclear count was negative except for numerous gram negative and gram positive bacteria.

The diagnosis was Botulism.

Treatment consisted of gastric lavage, polyvalent Botulinus antitoxin, (30 c.c. intravenously), calomel $\frac{1}{4}$ grain every 15 minutes for eight doses followed by magnesium sulphate 1 ounce two hours later; high colonic and water 16 ounces every four hours, and irrigations every four hours, milk 8 ounces strychnine $\frac{1}{60}$ of a grain every three hours by hypodermic. Owing to the extreme dysphagia, the fluids were passed into the stomach by means of the stomach tube, but this caused gagging and cyanosis and had to be discontinued. Murphy drip of glucose and sodium bicarbonate 5% was given instead, supplemented by nutrient enemata consisting of one egg, eight ounces of milk, and $\frac{1}{2}$ ounce of whiskey given every four hours. Cathartics were given frequently.

On admission the patients were very weak and in rather poor condition. After administration of the antitoxin and thorough cleansing of the gastro-intestinal tract, the patients

showed some improvement and were much brighter. Four days after admission they were able to swallow a little fluid and the eye symptoms began to clear up. Five days after admission the patients were able to take liquid diet and the nutritive enemata were discontinued. On the seventh day the patients were able to take soft diet. On the thirteenth day, they were allowed to get out of bed, but were still quite weak; and in the sixteenth day, they were discharged. The patients whose symptoms came on later, showed more severe symptoms and made slower progress to recovery.

Stool cultures were made under strict anaerobic conditions on meat-infusion broth and glucose-agar. A suspension of the stool in normal saline was heated to 60 degrees C. for one hour and then the cultures were inoculated at 37.5 degrees C. for ten days. Smears were made and stained with Gram stain. The culture showed formation of much gas of a very disagreeable odor. The stained smears showed bacillus botulinus with spores. This finding was corroborated by the U. S. Public Service. Guinea pig inoculation with the supernatant fluid of the centrifugized meat-infusion broth cultures were made and control animals were inoculated with sterile meat-infusion broth.

The first inoculation consisted of 1½ c.c. of culture and a corresponding amount of meat-infusion broth for the control. After 24 hours the guinea pig which was inoculated with the culture showed some malaise, while the other showed no reaction. There animals were re-inoculated with 2½ c.c. of culture and control broth respectively as before. At the end of 7 hours, the experimental animal showed loss of appetite and general weakness. At the end of 15 hours, there was paralysis of the lower extremities and gradually the entire lower part of the body became paralyzed. The animal took no food and lay motionless even when turned upon its back. Ptosis of the eyelids was also observed. Death occurred in 27 hours: probably from paralysis of the diaphragm. All this time the control animal showed no reaction: on the appetite and general activity being normal. Post-mortem findings on this guinea pig showed the stomach dilated and full of foul gas with a slight amount of partly digested food taken a few hours after the second inoculation. The caecum was also distended with gas and contained a great deal of focal matter. The heart showed a right sided congestion especially of the right auricle. The blood vessels in all the organs were markedly injected. Sections were made of the heart, lungs, liver, spleen and kidney. These sections showed degenerative processes in the heart, liver and spleen. The lungs were congested with blood. The kidney was normal and no organisms were found. Part of the spleen and liver were rubbed with saline solution and incubated overnight at 37.5 degrees C. Cultures from this suspension were made on meat-infusion broth under anaerobic condition and incubated at 37.5 degrees C. for eight days. This culture was centrifugized and 4 c.c. of the supernatant liquid was injected into a guinea pig. Another 4 c.c. of this culture was heated at 80 degrees C. for

½ hour to inactivate it and was then injected into a second guinea pig. A third animal injected with 4 c.c. of a pure sterile meat-infusion broth. Three and a half hours after injection, the animal which was inoculated with the inactivated culture developed convulsions and died. Post-mortem examination of this animal showed one large and multiple small abscesses of the liver. These had probably existed before inoculation and were the cause of death. The other two guinea pigs were symptomless after 48 hours.

Discussions:—Most of the workers on this subject have found that the toxin is inactivated by heating it at 80 degrees C. for ½ hour and that it cannot be formed in warm-blooded animals. The results of the second series of inoculations convinces us that our findings correspond to those of previous investigators. We also believe that the toxin ingested by the patients was not of a very virulent type because the symptoms cleared up in a short time. This may however have been facilitated by the early administration of the antitoxin. The fact that the guinea pig first inoculated marked symptoms until a second and much larger dose was administered; tends to with the original culture did not show any strengthen our belief that the toxin was not very virulent. That, in all probability, the illness of the patients was brought on by eating the squash which was improperly canned at home. We were unable to demonstrate the toxin or the organism causing it in the squash because the original jar which was used at this dinner was not available for experimental purposes.

We are indebted to Miss E. F. Paul, our laboratory technician, for her careful work in aiding to clear up the diagnosis on these cases.

Somerset County Hospital.—The laying of the corner-stone of the new \$400,000 County Hospital took place July 19th. The building will have three stories and a basement. There will be seventy-one beds and fifteen private rooms, two operating rooms.

State Hospital, Morris Plains.—We received the following communication last month.—
Editor:

Daniel S. Verrkees, Esq., president of the Board of Managers, in his annual report, says in speaking of the services of Dr. Marcus L. Curry, the Superintendent of the Hospital: "He has dealt with all issues in a masterly manner and his attitude has continually held the esteem and approval of the Board. Dr. Curry adds to scientific knowledge of psychiatry and a broad basis of exact observation and correct thinking a spirit of genuine personal interest which, together with his approachable manner and common sense attitude, enables him to adjust difficulties and harmonize opposite personalities, whether patients, employees, officials or members of the general public. He is characteristically open-minded, receptive to new ideas and improved methods and able to direct without arrogance and supervise without self-seeking. Only those in closest touch with the doctor realize how heavily the obstacles and criticisms which he has encountered in the past year weigh upon his mind and how lavishly he has spent his strength and energy

in continual effort to cover personally every branch of hospital activity. We of the Board are deeply appreciative of the remarkable work which he has accomplished for the hospital and its inmates, and we rest assured that the policies and administration of this great institution have been entrusted to faithful and competent hands."

Hospitals in New York and Brooklyn.—The Bronx Hospital has changed its tradition of excluding women from its staff, by appointing Drs. Pauline Seller and Anna Koslow, graduates of Bellevue Hospital Medical College, as interns. The State Board of Charities has issued a charter for the erection of an Italian Hospital in Brooklyn. A \$1,000,000 hospital building drive fund will be conducted in the fall for this purpose.

Hospital for Crippled Children.—Ground was broken June 24, by the mayor of Philadelphia for the Shriner's Hospital for Crippled Children on Roosevelt Boulevard, adjoining Pennypack Park. In addition to this hospital on Roosevelt Boulevard, a fund is being raised to build and endow the W. Freeland Kendrick Convalescent Home for Crippled Children, which will adjoin the Shriner's Hospital.

Hospital For Indians.—Two new hospitals will be opened this month by the Government for the care and treatment of Indians. One of these will be a seventy-five bed tuberculosis sanatorium at Onigum, Minn., and the other will be a seventy-five bed general hospital at Shawnee, Okla. It said there are 13,351 Indians living in Minnesota, among whom are 480 cases of tuberculosis.

Bonnie Burn Sanatorium.

Dr. John E. Runnels, superintendent, reports as follows: On May 31st there were 261 patients in the sanatorium, 152 males and 109 females. This included 84 children in the Preventorium. Since the last report 36 patients have been admitted, 17 males and 19 females. Fourteen of these admissions went to the Preventorium. The admissions are classified as follows: Pretubercular, 14; incipient, 0; mod. advanced, 6; far advanced, 16. The largest number of patients present at any time during the month has been 287.

Marriages.

BAKER-POWERS. — At Stanhope, N. J., July 16, 1924, Dr. Augustus L. L. Baker of Dover, N. J., to Miss Margaret K. Powers of Stanhope.

BRODY-SOKOLOFF.—In New York City, July 1, 1924, Dr. Morton S. Brody of New Brunswick, to Miss Sophie Adele Sokoloff of New York.

Deaths.

HOOD.—At Newton, N. J., July 8, 1924, Dr. Bruno Hood of that city.

Dr. Hood was born in Germany and came

to this country when six years old. He graduated from the College of Physicians and Surgeons, N. Y. City in 1885; practiced medicine in Newark three or four years, and since then in Newton and vicinity. He was a member of the Sussex County and the State Medical Societies, and a Fellow of the A. M. A. He had been a member of the local Boards of Health and Education and a director of the Newton Trust Company. During the World War he was a member of the local Draft Board.

RAFFERTY.—At Red Bank, N. J., July 20, 1924, Dr. Peter P. Rafferty, aged 49 years.

Dr. Rafferty was graduated from the New York University Medical School. He was a member of the visiting staff of Monmouth Hospital, and if the board of managers of the New Jersey Hospital. In the World War he was promoted to major and was assigned to the command of the field hospitals of the Rainbow Division.

TOWNSEND.—At Paterson, N. J., June 2, 1924, Dr. Samuel Cyrus Townsend, aged 71 years. Dr. Townsend graduated from Bellevue Hospital Medical College in 1879. He was a member of the Passaic County and State Medical Societies; was formerly a member of the State Board of Health.

Public Health Items.

Newark Mortality Report.—There were 455 deaths in Newark during the month of May, or a death rate of 4.9 per 1,000 of population. The principal causes of death were: Tuberculosis, 43 cases; cancer, 33; apoplexy, 29; organic heart disease, 50; pneumonia, 45; Bright's disease, 31.

New Jersey Mortality Report.—There were 3,612 deaths in New Jersey during May, according to reports filed with the State Bureau of Vital Statistics. The death rate for the month was 12.33, a decrease of about one point from the previous month. There were 458 deaths of children over one year and under five years and 1,295 deaths of persons sixty years or older.

Vaccinate All Pittsburgh.—On July 5, physicians were sent to nineteen public health clinics to vaccinate citizens in accordance with the mandate issued by the city health board, ordering all residents of the city to be vaccinated to prevent a smallpox epidemic. There have been eight deaths from smallpox reported since June 8.

"Makes The Weak Strong."—How nimbly and trustfully we go from one fad to another, seeking always the short and easy cut to cure and restored health. From Fletcherism to Tan-lac; from the "Key to the Calories" to Fleischmann's Yeast; from vitamins to monkey glands; from Coue to Abrams. Every day, in every way—Next!—Bulletin. Indiana State Board of Health.

Epidemic of Vaccination.—Ten thousand persons were vaccinated in Cleveland, Ohio, last

month as a precaution against smallpox. Eighty-three cases have been reported since January 1 with four deaths and other cases have occurred in surrounding towns. Dr. Rockwood says "there is now an epidemic of vaccination."

The Bugaboo of High Blood Pressure.—

Patients should be made to realize that physicians are coming to a better understanding of the problem, that they are gradually getting away from the bugaboo of high blood pressure as an entity. May the day soon pass when patients are told that their blood pressures are high, and may they be made to believe that the hypertension phase of their malady is no more important than other aspects of a generalized disturbance not perhaps apparent to them.—W. J. Stone: California State J. M.

States Bar Alien Physicians.—Following the lead of several other states, the state board of medical examiners of Texas announced, June 18, that aliens will not be permitted to take the examination for license to practice medicine in that state until after they have filed their application for naturalization papers. The other states which have taken action relative to foreign physicians are:

Indiana, Nebraska, Arizona, Florida, Maryland, New Hampshire, Oklahoma, Louisiana, Illinois, New York, Michigan, Pennsylvania.

The majority of these states require actual citizenship (residence of five years) and all but a few states in the country require that the examination be written in English. Since the recent influx of foreign physicians to this country, following the depreciation of money in Europe and other economic conditions, other states are contemplating action along these lines. In Idaho, the department of law enforcement does not recognize medical schools outside of the United States and Canada and physicians before being registered must first become citizens of the United States.

Pitfalls of Practice.—As I have been qualified now more than thirty years, I can look back on a period of varied practice sufficiently long to note incidents standing out so often that I may call them danger signals, the presence of which it is unsafe to ignore. The chief pitfalls in medicine are: 1. Neglect to make a thorough examination of every patient, and accepting as correct the statements made by the patient about what the other doctor said was the mater. 2. Concluding, when you find an incurable condition of which the patient is obviously ignorant, that you are the only man to have found this trouble. 3. Omitting to tell some responsible member of the patient's family when you discover a condition in which it is against the patient's interest that he or she should be told the truth. 4. Neglecting to share responsibility whenever possible in a serious illness, or undertaking operations which have looked so simple at the hands of an expert, out which may prove the reverse at the hands of the less experienced. 5. Refusing to meet the medical man asked for by the patient.—Bruce-Porter: Pitfalls of Medical Practice, Practitioner.

Dr. H. J. Wallhauser, in the June issue of the Bulletin of the Newark Department of Health, gives the result of the hearings and deliberations of the N. J. Commission for the Determining What Occupational Diseases Should be Subject to Compensation and to Suggest Legislation to that End, and gives the following occupational diseases as compensable: Anthrax, lead poisoning, mercury poisoning, arsenic poisoning, phosphorus poisoning, benzene and its homologues and all derivatives thereof, wood alcohol poisoning, chrome poisoning, caisson disease. He then gives in condensed form the symptomology of this group of occupational diseases.

The Strength of the Nation.

The future strength of a nation lies in its children and is largely dependent upon their wholesome physical and moral development.

The girls of today are the women of tomorrow, and as future mothers their influence will mould growing womanhood and eventually control the destiny of the race. Girlhood can be a most valuable national asset or a great liability. The future womanhood of every girl and the place she takes in the world will depend in large measure upon what we do for her and what we encourage her to do for herself.

The object of the Girl Scout organization is to give girls natural, wholesome recreation, and to establish those habits of mind and body which will lead to healthy, moral and responsible womanhood.—Mrs. William E. Dever.

Personal Notes

Dr. Wells P. Eagleton, Newark, and wife left on June 10th for a trip around the world, sailing from San Francisco July 18th, for South Sea Islands, Australia, India, etc. The doctor will visit several hospitals and send reports to the State Society Journal. They will return the latter part of December.

Dr. Berth S. Pollak, Secaucus, sailed for Europe June 28th. He is a delegate from the U. S. Association to the International Congress on Tuberculosis in Lausanne, Switzerland. He will return September 1st.

Dr. John F. Hagerty, Newark, and wife sailed last month for the British Isles, Italy, etc. They will return early in September.

Dr. Julia C. Mutchler, Dover, is recovering from a severe illness. She expects to resume work as a physician and as an Alderman of Dover about September 1st.

Dr. Obadiah H. Sproul, Flemington, graduate of the University of Pennsylvania School of Medicine in 1866, celebrated his eightieth birthday recently. He was president of the State Medical Society in 1894 and has attended every annual meeting but two during the past sixty years.

Dr. Benjamin Gutmann, New Brunswick, who has been spending a few weeks in Europe, will return about August 10th. He announced that after August 15th his office hours will be: 2 to 4 and 7 to 8 P. M. In the morning by appointment only, 8 to 9 o'clock.

Continued on page xxii.

On the main line of the Lehigh Valley and the Central Railroad of New Jersey. Three and one-half hours from Philadelphia. Four hours from New York. Eight hours from Buffalo. One hour from Wilkes-Barre.

SUNNYREST SANATORIUM

White Haven, Pa.

A Private Sanatorium for Incipient Cases of Tuberculosis

LOCATED high in the Blue Mountains of Pennsylvania, 1,300 feet above sea level, you have at your very doorstep the best of the delightful scenery of a region noted for its natural beauty and healthful climate.

There are both cottages and individual bungalows. All rooms are private.

For patients on exercise, there is a centrally-located dining-room. Bed patients are served by competent maids. There is an experienced *chef* with a natural appreciation for good and wholesome food.

There are modern facilities for the most advanced methods of treatment. There are specially trained graduate nurses always in attendance.

Patients with a natural appreciation for comfort, service and amusement, will find Sunnyrest a delightful place. For those on exercise, there is a newly finished miniature outdoor golf course with all the thrills and hazards of a full-length course. There are wide

verandas and comfortable chairs. There are charming walks through woods of spruce and pine and oak.

Patients are under the direct medical supervision of the following well-known physicians: Drs. H. R. M. Landis, Joseph Walsh, Frank A. Craig, Isadore Kaufman, Elmer H. Funk, all of Philadelphia, and Dr. Alex. Armstrong of White Haven.

Terms for private room in Cottages: \$30.00, \$32.50, \$35.00 and \$40.00 per week. Terms for individual bungalows with private bath and dressing-room: \$45.00, \$50.00, and \$60.00 per week. This includes everything but Medical Fees.

Reservations are now being made. For particulars, address:

IVAN F. GOODRICH, Gen'l Manager

Sunnyrest Sanatorium (East Side) White Haven, Pa

Orange Publishing Company

Printers, Publishers
and Stationers

14 So. Day Street,
Orange, N. J.

Trade
Mark
Reg.

STORM

Trade
Mark
Reg.

BINDER AND ABDOMINAL SUPPORTER

(PATENTED)



Trade
Mark
Reg.

Trade
Mark
Reg.

For Men, Women and Children

For Ptosis, Hernia, Pregnancy, Obesity, Relaxed
Sacro-iliac Articulations, Floating Kidney, High
and Low Operations, etc.

Ask for 36 page illustrated folder. Mail orders filled
at Philadelphia only within 24 hours

Katherine L. Storm, M.D.

Originator, Patentee, Owner and Maker

1701 Diamond St., PHILADELPHIA

PERSONAL NOTES.

Continued from page 274.

Dr. Lancelot Ely, Somerville, has been promoted from the rank of major to lieutenant colonel in the U. S. Army Reserve Corps. He was in the World War as first lieutenant.

Dr. W. Blair Stewart, Atlantic City, had a two weeks' vacation in the Cumberland Valley at Carlisle, Pa.

Dr. Barth. M. Howley, New Brunswick, and family are spending the month of August at Moose Pond, Haine.

Dr. Walter G. Mead, Arlington, and wife, recently returned from a motor trip to Belmar.

Dr. Samuel C. Haven, Morristown, and family, left for Milford, Nova Scotia, July 19, where they will spend several weeks.

Dr. Charles B. Kelley, Jersey City, has been appointed a member of the State Board of Medical Examiners, to fill the vacancy caused by the death of Dr. J. J. Mooney.

Dr. George C. Albee, South Orange, and family is on a motor trip to the Pacific Coast, by way of the Grand Canyon and the Yosemite Valley.

Dr. William J. Arlitz, Hoboken, delivered a lecture at the State Department of Labor headquarters last month in which he said that more than fifty per cent. of all accidents occur in homes and therefore first aid should be learned by laymen.

Dr. Frederick P. Wilbur, Franklin, and wife took an auto trip last month to Skaneateles, N. Y., their former home.

Dr. Charles F. Halstead, Somerville, and wife are spending a few weeks' at Sebec Lake, Maine.

Dr. Frederick W. Flagge, Rockaway, and wife spent two weeks at Green Pond recently.

Dr. Earl L. Creveling, Jersey City, has moved his office to 2700 Boulevard, Daniel Apartment, that city.

Dr. Arcangelo Liva, Rutherford, will hereafter limit his practice to Diseases of the Eye, Ear, Nose and Throat.

Dr. Herbert W. Long, Newark, wife and daughter are at Budd Lake.

Dr. Sidney E. Pendexter, East Orange, and family are at their summer cottage in Maine, until August 15th.

Dr. Charles F. Abraham, East Orange, is spending a month at Block Island.

Dr. Herbert W. Foster, Montclair, and wife are on a motor trip in New England. They will spend a month at Boothbay Harbor, Maine.

Dr. Robert F. Ringland, Montclair, and wife are at their summer cottage at Craigville, Mass.

Dr. William M. Brien, Orange, and son took a fishing trip last month to Barnegat Bay.

Dr. Samuel H. Baldwin, Newark, and wife took a motor trip to Binghamton recently.

Dr. Christopher A. Brokaw, Elizabeth, was elected Union County physicians by the board of freeholders last month to succeed the late Dr. F. W. Westcott.

Dr. Charles B. Smith, Washington, and wife are taking a trip to the Great Lakes this month.

Dr. Thomas J. Smith, Bridgeton, who has been a member of the staff of Bridgeton Hospital since its organization in 1898, has resigned.

Journal of The Medical Society of New Jersey

Published on

the First Day of Every Month



Under the Direction

of the Committee on Publication

Vol. XXI, No. 9 ORANGE, N. J., SEPTEMBER, 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

WHY THE PUBLIC CONSULT THE PSEUDO MEDICAL CULTS.

Oration in Medicine, delivered at the 158th Annual Meeting of the Medical Society of New Jersey, June 6, 1924

By **Edward J. G. Beardsley, M. D.,**
Philadelphia, Pa.

The physician does not live whose heart would not beat a little faster and whose blood pressure would not rise at the thought of addressing an assembly of the representatives of the oldest existing Medical Society in the United States. I sincerely appreciate the courtesy that your officers have shown in inviting me to be a speaking guest at this one hundred and fifty-eighth annual session of the Society.

One may, unfortunately, be ever so deeply appreciative of this honor, and, at the same time, be uncomfortably conscious of his inability to present a theme worthy of the traditions of this Ancient and Honorable Association and of the distinguished audience that has gathered here.

In considering how I might best serve the Society, it occurred to me that the members might be interested in a brief summary of the reasons why a large number of representative citizens consulted others than properly educated and legally licensed practitioners of medicine regarding their physical and psychic ills.

The excuse for selecting this particular topic is that the subject has interested me for a number of years and my opinions regarding the matter are based upon a study of the statements made by patients.

It may serve to make clear the reasons for having instituted such an inquiry if it is stated briefly how the matter came to especially interest me. In 1917, in common with hundreds of physicians from this and other States, I had the opportunity, during military service, of obtaining a new

impression of the medical profession and its practitioners.

Before entering the military service I had lived too close to the problems of medical education and of the methods of hospital practice to realize clearly many of the important problems that were confronting the medical profession.

During the intimate contact with physicians from nearly every State in the Union that Army life afforded there was the time and opportunity for discussing and hearing discussed all phases of medical subjects. It was at this period that I made the humiliating discovery that I was lamentably ignorant concerning many of the important sociological and practical problems that were vital factors in modern medical life.

Living in a community, as I had been fortunate enough to do, that we that love Philadelphia like to speak of as conservative in its tendencies, though its critics have harsher terms for its customs, I had not been seriously impressed with the menace to the profession by the advent and rapid growth and development of the various pseudo medical cults. Those physicians, however, that lived and practiced in sections that were already heavily infected with the manipulators of osteopathy, chiropractic, neuropathy and similar sects, were fond of prophesying dire results to both the public and the medical profession unless stringent legislation was enacted to control the problem.

As was to be expected and as is true today, the practitioners whose education and training had been deficient and whose methods of medical work were least efficient, were the men who felt most keenly the effect of competition with the cleverly advertised and advertising agents of the cults.

One thing that particularly impressed me

in listening to the stories of practitioners, temporarily acting as medical officers in the Army regarding the keen competition that was felt as the result of the activities of the cult followers and that was that it seemed frequently to be the case that the more enlightened, in other knowledge than medical science, and apparently more progressive citizens of the various communities were the citizens who were consulting the representatives of the cults.

The subject began to have a real interest for me and it continues to elicit my serious attention.

My duty in the military service was such as to afford an excellent opportunity for observing the methods of work, the mode of thought and the resulting efficiency of large numbers of medical officers.

Army physicians, like physicians in civil life, could be classified in four general groups.

1. A relatively small number of unusually well educated, exceptionally trained physicians and surgeons who were vitally interested in medical work and consequently were efficient and dependable.

2. A larger group, frequently well educated in medicine and in science but the members had not, for one reason or another, received the necessary technical training or who, having once had the training, gradually acquired careless methods of performing their medical work. The members of this group could and did acquire much of the necessary training that they lacked and greatly increased their efficiency becoming skilled men who could be counted upon to perform excellent work.

3. A still larger group, the members of which were deficient in scientific education and medical training, and, the majority of whom had never had the opportunity of improving their methods by working with men of better training. The members of this group were, usually, anxious and willing to learn new and better methods of work and frequently made real progress toward improvement but, as a rule, the members were badly handicapped by their lack of early medical instruction and their deficiencies in thorough technical training.

4. A group, fortunately, smaller than any but the first but still too large. These physicians were not vitally interested in medicine. They were, more often than not, good companionable men and were willing and able to do the hardest and most dangerous work but they had no real interest in scientific medicine.

It is obvious that, in the event of the entire medical profession being selected for service, we would find that heredity, environment and the fortunate opportunities for study and training in the past would, in a great measure, determine which group of the above gross classification each one of us would join. Certainly it is true that members of the least efficient group would, in some special field of service, be superior to others of greater knowledge and superior technical training.

Two years spent in intimate contact with large numbers of medical officers supplied the opportunity for daily witnessing both the best and the least efficient methods of work in medicine. One had the opportunity of meeting the finest type of physician or surgeon and one, all too frequently, encountered medical men who were pathetically ignorant, and, what was worse, so careless in their work that they proved a liability instead of an asset to the military service. In these modern days time appears to pass so rapidly that it already seems a far cry to the days of the war. Is it not wise, however, for the medical profession to ponder over and, if possible, to profit by the medical lessons of the war? It is not well for us to question whether we physicians, as a group, were efficient even in our strictly medical duties? Was it easy or difficult to find competent, efficient and trustworthy physicians to fill positions of responsibility in the medical corps? It is not reasonable to suppose that all the poorly equipped and careless physicians of our country were in uniform during the war, nor is it a plausible theory that the transfer of a medical man from his civil practice to an army camp or hospital would lessen his efficiency in medical work.

The impression that became indelibly fixed in my mind during military service was that the patients of a physician, whether soldiers or civilians, were to be pitied if their doctor did not have, and was unwilling to acquire, a systematic routine in his physical examination and methods of work. One came to sympathize with the patients in civil life who felt that they were not getting from their physicians efficient care. After seeing so much careless and indifferent medical work performed in the same camps and hospitals where there was also being performed the best medical and surgical work that could be performed one could not but wonder whether the public always receive, from members of the medical profession, all that it has a right to ex-

fect in the way of practical, skilled and efficient medical services.

When I returned to civil practice in 1919, it soon became evident to me that there had been a great change in the mental attitude of the public toward the practitioner of medicine. The physician did not seem to occupy as high a position in the affection of the public as formerly and he shared, to a certain extent, the public's favor with the osteopath, the chiropractic and similar manipulators.

At first I was inclined to believe with those who ascribed all new or formerly little noted phenomena to the well known restlessness of after war conditions but this explanation was never satisfactory and was soon abandoned. The more I studied the matter the more I was reluctantly compelled to admit to myself that the fault lies, in a great measure, in the medical profession itself. It also became evident to me that as long as we deceive ourselves by ascribing the growing unpopularity of the medical profession with the public to other than the true cause, i.e., our own carelessness and inefficiency, the longer will we fail to correct the fault.

For the past four years I have made it a part of the medical history of all patients to inquire what their experience had been with the cults and what their reasons were for consulting these individuals rather than the representatives of the medical profession. The results of these systematic inquiries have given me, as a medical teacher and practitioner, much food for serious thought and have been, not a little, disquieting. It will be well to place briefly before you certain of the results of this inquiry.

Of the patients seen at my office during the past four years, 34 per cent. had, within three months of the time of their first visit to me, been under the care of agents of one or more of the numerous cults. During the same period, of the patients examined by me in a free dispensary connected with one of the larger hospitals of Philadelphia, 26 per cent. of the patients questioned stated that they had been receiving treatment through pseudo medical agencies.

When one considers that 34 per cent. of private patients and 26 per cent. of dispensary patients have been receiving treatment for their physical and psychic ills through agencies outside the medical profession it seems worth while to learn, if possible, the reason for the wholesale desertion of the medical profession.

A careful inquiry into the chief causes for dissatisfaction with the former physicians whom the patients had abandoned, revealed that 86 per cent. of the private patients and 97 per cent. of the dispensary patients complained that they had not been examined by their doctor or had been examined so superficially that the patient considered that the examination was valueless. It was found that only 9 per cent. of the private patients and none of the dispensary patients had been completely examined by the physicians whom they had consulted.

The next most frequent complaint encountered in an analysis of the legitimate cause for dissatisfaction was that the physician was too busy to devote the time and attention that the obscurity of the symptoms in the individual cases demanded.

The third cause for dissatisfaction, not as frankly stated but met with too commonly to be ignored, was that the patient was impressed that the physician consulted was more interested in receiving a fee for services than he was rendering full value for the fee received.

Sixty per cent. of the private patients interviewed stated, on their own initiative, that they were perfectly willing to pay larger fees for medical services if they could feel they were being carefully and efficiently studied and treated.

The fourth common causes for dissatisfaction among the patients was the observation concerning the expense and waste of medicines ordered at successive visits, and, almost as frequently, the complaint that the medicine ordered made the patient feel worse than before taking it.

The fifth common cause for dissatisfaction was an inability to understand why there was such a difference of opinion among physicians regarding an uncomplicated illness. Opinions, at variance, could be obtained from, so termed, good doctors, without careful physical or laboratory examinations and with no serious attempt to prove or disprove the diagnosis made by special efforts, i.e., x-ray examinations, Wassermann and other tests.

There were other causes for dissatisfaction mentioned as is to be expected. Many of the causes were unreasonable, unjust and unworthy of serious consideration while other causes for dissatisfaction were based upon stories of neglect and carelessness exhibited by physicians, that, when hearing but one interpretation of the incident, made the attending physician's behavior seem almost criminal.

We live in an age in which the profession of medicine is freely criticised. The statement is commonly made that physicians, not infrequently, fail to return full value in scientific diagnosis, care and thought for the money received from patients. The most distressing feature of such criticism is, in too many cases, its justice.

That it is unfair that the entire profession should be condemned because of the failure of certain members to live up to their obligations and opportunities is obvious, but that there should be so many occasions for just complaint against members of the medical profession is most unfortunate. No lay critic can possibly be as well informed, as is the physician, regarding the amount of inferior medical work done. It is important, therefore, that the united profession should earnestly seek for the causes that result in the poor or indifferent professional work done and apply such remedies as will lead to a correction of the evil. There comes a time when unpleasant truths must be faced in order that the necessity for change and improvement become known.

It is an age where the public demand efficiency whether it be regarding the performance of a motor car or the family physician. The public is intelligently interested in medical problems. If I interpret the mental attitude of the intelligent public correctly I believe that they are demanding efficiency in medical diagnosis and treatment more than ever before.

If the regular medical profession is not prepared or will not prepare itself to do better and more efficient work than it did fifteen years ago the public is ready to seek, even vainly, for medical help elsewhere. The truth appears to be that many of us in the medical profession have drifted, almost imperceptibly, into dangerous habits of lack of proper system and acquired the careless methods of work which lead, almost inevitably, to danger for our patients.

It is not, as a rule, because we lack knowledge, but rather that we frequently fail to use the knowledge that we possess.

It is a well recognized fact that there has never been a time in the history of medicine when the scientific preparation and training for those who seek to become members of the profession has been so generally satisfactory. There has never been a time when the clinical and laboratory training for undergraduates has been more thoroughly carried out than it is today. Why then should there be so much per-

fectly honest and essentially just criticism of the medical profession?

The answer lies, in part, in the lack of a proper sense of professional responsibility and a lack of proper ideals in a certain percentage of physicians. Many of the licentiates of medicine are becoming "good business men" who mistake the relative value of quantity of medical work done for the quality of real professional services rendered.

The modern business man of the best type has a code of business ethics that might well be adopted by those physicians who are in the medical profession "for what they can get out of it" and not for the amount of service they can render the public.

If judged by proper professional and scientific standards a great deal of the medical work performed by a proportion of physicians would be condemned. A greater number of medical offenders, however, gradually drift into the careless medical methods for the lack of some impelling example to do better and more valuable work.

Professional success of the highest type in medicine can and should be judged by the amount and kind of professional work performed in the interest of the patient, the public and the medical profession rather than by the financial income and material prosperity of the physician.

Financial success that has its foundation based upon industry, efficiency and the best kind of professional work is not only admirable, but it is, and should be a source of healthy inspiration to all physicians. An income from the medical profession, however, that is acquired as a result of, consciously or unconsciously, lowering one's professional ideals and, more particularly when gained at the potential sacrifice of the health of patients, as a result of careless and insufficient clinical study is not to be envied.

In the every day work of medical practice, as in the world of business, the qualities of absolute honesty, integrity and consistent industry are far more important than brilliance of intellect or flashes of genius, valuable and stimulating as are these later traits.

In any reputable business today all goods are guaranteed, and, if they prove unsatisfactory they can be exchanged without cost or prejudice. Standard goods are the rule and not the exception and sharp practices are infrequently met with.

Can we, as a profession, state with honesty that all medical services are guaranteed to be the best that we are capable of giving?

If we do not give to each patient who consults us our best services we lower our standard as well as aid in lowering the standard of medicine in the city or town in which we are licensed to practice. One of the greatest deterrents from doing our best professional work is that we do not make careful physical examinations. The failure to provide office kimono or similar covering is frequently made an excuse for not carrying out the complete examination that should be made of our female as well as our male patients.

There are a few lessons more important for the seacher after truth in medicine to learn that the necessity for and the importance of having the part of the body to be examined as free from covering as possible and of having the aid of good light in conducting the examination. True modesty is of the mind and the heart, and, although the natural feelings of delicacy in a patient should be, as far as is practical, considered, any false ideas of modesty that are encountered should be overcome by proper education. The nearer we approach the ideal of examining a patient in a well lighted room and in a practically nude state, the more quickly will clinical medicine free itself from many of the too common and often ridiculous errors in diagnosis.

One must use tact and judgment in adopting such a seemingly radical plan of examination and one must provide suitable loose covering so that women patients will not be unnecessarily embarrassed or offended during the examination. The more intelligent the patient and the more efficient the medical profession in the community, the less hesitation there is in carrying out with perfect freedom the necessary examinations.

The patient's ignorance, indifference or actual dislike for an examination should not prevent our performing such as we know to be wise and necessary. The patient cannot possibly understand the necessity for technical procedures unless he has been educated by the physician.

The therapeutic value of a complete physical examination when fortified by proper laboratory work has never been sufficiently emphasized. The average patient thoroughly appreciates a complete and thorough examination and values it highly. It is un-

fortunately true that one of the most important and suggestive statements made by patients who have been under the care of sectarians in medicine was that they were carefully examined before being given manipulative treatment. The patients frequently defended their action in visiting the agents of the cults by stating that their own physician never examined them.

During the past few years it has been noticeable that the cults are educating their disciples not only to make physical examinations but to examine the urine and blood. Wassermann tests of blood and spine fluid are frequently requested by them. The representatives of the cults believe in applied psychology.

Would it not be well for the medical schools to eliminate attempts to make skilled specialists of undergraduate students but to increase the amount of practical work and to make a place in the curriculum so that the psychology of every day life could be properly taught by skilled teachers. This important branch should be taught, however, with the object of aiding the future physician to help the patient rather than for the specific purpose of aiding the physician to increase his income. It is at least a debatable point whether the average patient that is not thoroughly examined does not occupy as much of the physician's time as would be necessary to examine him thoroughly. Not a few physicians see many patients in a day but miss all the professional pleasure of their work by never performing it in a truly professional and efficient manner. Such physicians treat symptoms empirically and make no serious attempt to discover the exact cause of the symptoms. That many of these men are extremely clever in recognizing various physiologic and pathologic states, makes it all the more regrettable that they do not devote their undoubted skill and talent to a more serious study of their patients. Any criticism of superficial methods in medical work is very frequently met with the excuse that the fee collected is too small to compensate for thorough work. One must bear in mind, however, that such reasoning is not based upon truth. The patients who make frequent visits and pay small fees are, as a rule, as remote from a thorough examination after a number of visits as they were when first seen, while the aggregate sum paid for inferior services is large.

Profesional work of the superficial, and, unconsciously, dishonest kind is little removed from other schemes for taking

money from citizens under false pretense. When one seriously considers that among the patients thus superficially examined and as casually treated there must be, at times, individuals suffering from the early and perfectly curable stages of certain diseases it must make us realize the serious responsibilities as well as the great privileges of our professional work.

There are few present that would disagree with the statement, that, if every properly licensed physician in the State of New Jersey or any other State in the Union, did his professional work as well as he knows how to perform it, the agents of the pseudo medical cults would disappear in less than a year. It is the crowded office hours apparent necessities that leads practitioners to the pathways of professional carelessness. Is health and life so much less important than the overhauling of a motor car or the repair of a watch?

The public demands and receives efficient repair work in those branches and they know that such adjustments take time and cost money. Have they not a right to expect and demand efficient services when their health and even their lives are at stake?

That medical fees are, in general, too small to compensate for proper medical service is true. Where lies the fault that this should be true? When the medical profession is ready to adjust its relations with the public, in the way of giving the public the skilled service on all occasions that it is capable of, then there will not be the necessity for so many office or house calls. There will be time for the physician to make the proper studies and the public can be educated to pay fees commensurate with the value of the services rendered.

I do not wish to be misunderstood concerning the question of medical fees. I believe that *any* fee paid for indifferent, careless or casual service is too high for any but a wealthy and, especially, a healthy patient to pay. It is the working man and woman, the patient of moderate means, that need the greatest skill and the best judgment in diagnosis and treatment when they are ill. It is for them, as it is for those of greater financial resources, the best kind of economy to pay well for efficient service rather than to drift into a state of invalidism for the lack of proper professional advice. No one knows better than I do that it is not the doctors who attend medical conventions who most need to be reminded that they have serious responsibilities in

performing their daily professional duties. It is far more likely to be the practitioner who is "too busy" to attend such gatherings that would be benefited by having his attention called to the fact that the State licenses each physician, not for for the purpose, as some believe, of aiding the physician to make money but rather that the health and lives of the citizens should be safeguarded by the advice and skilled services of the licentiate.

One of the greatest and most enduring professional pleasures of a medical teacher is the satisfaction of observing the deserved success that comes to former students. One of the disappointments in a teacher's life is the realization that a proportion of the medical men whom one has watched, guided and admired as students have gradually degenerated into performing their professional work in a manner and by methods that are not a credit to their profession, their former teacher or to themselves.

In talking to such men, as are approachable, about their acquisition of careless medical habits, one encounters two common excuses.

First, they find themselves "too busy" to do their professional work properly and, second, they see all about them successful practitioners, their seniors in years, experience and knowledge, who do not find it necessary to carry out the careful, orderly procedures and investigations that were taught in the medical college and in the hospitals in which the younger physicians were trained.

Let the medical school and the hospital staff do all that it may to inspire and to properly train its students in the best methods available but if the senior physicians of their communities do not set their juniors an example in method, care and thoroughness the young practitioners will, almost inevitably, drift into careless methods of work and they, unfortunately, have not the years of experience to prevent their making serious blunders. There can be no satisfactory excuse for carelessness in the practice of medicine. Health and all that it means in the pursuit of happiness and success and disease and all that it implies of suffering, pain and discomfort of mind and body are too vital matters to be carelessly treated.

Can we not take more time for the investigation of the ills of our office patients by insisting, when this seems practical, that our consultations shall be appointment. Let us resolve to do the professional work that

we are capable of rather than be driven to doing indifferent work by the pressure of too many appointments.

The Golden Rule is an excellent religion for a physician to live and practice by. It is not always those that are physically ill that most need our sympathy and help. Can a cultist do as much for the victim of psychasthenia as can a sympathetic, understanding and interested physician? Have we not all neglected opportunities for being helpful to those suffering with both minor and chronic ailments? Such conditions may not be vitally interesting to the physician but the patient cannot be in a position to understand or appreciate that point of view. The medical cults have always existed in some form or other and probably always will. We must, as a profession, see to it that they do not exist as a protest against our failure to meet the needs, actual or psychical, of the public.

PROSTATIC HYPERTROPHY.

By Louis L. Davidson, M. D.,

Newark, N. J.

Visiting Urologist, Newark Beth Israel Hospital.

During the past fifteen years such rapid progress has been made in the methods of diagnosis and treatment of genito-urinary diseases, that urology is now recognized as one of the most accurate of scientific specialties. With the development of the cystoscope, renal catheterization, kidney functional tests, pyelography and blood chemistry, not only can an accurate diagnosis be made and the proper treatment instituted, but the prognosis, in which after all the patient is most interested, can be determined with a reasonable degree of accuracy.

That physicians are familiar with these diagnostic aids, is evidenced by the frequency with which suspected cases of surgical diseases of the kidney, ureter or bladder are referred to the urologist for a diagnosis; but for some unexplainable reason the general practitioner is more reluctant in referring cases presenting early symptoms of prostatic hypertrophy, either minimizing the significance of these symptoms or perhaps still being under the impression that a prostatectomy is too serious an operation to advise unless forced to do so on account of extreme suffering or acute retention.

This conclusion has been formed after

a careful analysis of all the cases admitted to the Urological Service of the Newark Beth Israel Hospital during the past five years. All of our cases were suffering from acute or chronic retention or incontinence from over distention and from secondary renal and cardiac insufficiency. The average case could be described as follows: a man of about seventy years of age with a facial expression indicative of pain and suffering, with a distended bladder extending to the umbilicus with an inguinal hernia, hemorrhoids, and prolapsed rectum; frequently we find edema, dyspnoea, varicose veins and other evidence of cardiac decompensation; in the cases complicated by a cystitis and stone formation the suffering is more excruciating and they present in addition evidences of a retrograde pyelonephritis.

A careful history in these cases would reveal that symptoms of prostatism had existed for several years; many of them will give the date of the first attack of complete retention as the beginning of the trouble, but persistent questioning will bring out that nocturnal frequency had existed for a long time, that they also voided every two or three hours during the day, that for a long time they experienced some difficulty in starting the stream and that it required some straining to expel the urine; they will recall that their sleep was more and more disturbed by the desire to urinate and that the frequency became more urgent and required stronger straining efforts, that they began to be troubled with hemorrhoids and observed the appearance of a small hernia which gradually increased in size; as time progressed all these symptoms became more aggravated followed by one or more attacks of complete retention, which were relieved by a hot bath or a catheter and finally as a last resort were sent to the hospital.

We now have not only an old man with an hypertrophied prostate to deal with, but one whose kidneys and cardio-vascular system have been so damaged that any immediate surgical treatment would probably prove fatal.

The attending physician who sends his case to the hospital probably does not realize that this benign bladder obstruction is the cause of all the complications mentioned; a superficial review of the pathology would readily explain all of the symptoms and complications. The hypertrophied prostate surroundings the vesi-

cal neck, produces a mechanical obstruction of the bladder outlet; the prostatic urethra becomes lengthened and distorted, the urethral opening in the bladder is elevated forming a pouch behind it where the urine accumulates, the increased straining to expel this residual urine causes enlargement of this post-prostatic pouch; there is a marked hypertrophy of the bladder following if not relieved by atony; the ureteral orifices are compressed and distorted by the hypertrophied bladder producing a dilatation of the ureters and kidney pelves; fibrotic changes in the kidneys soon follow and toxemia and cardiac decompensation complete this vicious circle. It is evident had the obstruction been removed before all this pathology had appeared, not only would a good deal of the distress, pain and suffering have been prevented, but a prostatectomy on a comparatively healthy individual would be considered a minor operation with an exceptionally low mortality and many useful and comfortable years would be added to the patient's life.

That the average case sent to a general hospital is far advanced, and presents most of the complications above mentioned, can be better appreciated by a detailed analysis of the last ten cases admitted to the urological service of our hospital.

Of this series of ten consecutive cases of obstructive prostatic hypertrophy, the youngest was 57 years and the oldest 78 years, the average age was 67.3. Eight were admitted with a diagnosis of acute retention; two with chronic retention. Albuminuria in six cases, hematuria in three, Pyuria in four cases. Stones in the bladder were found in three cases. Eight cases gave a history of polyuria and nocturia, and two of incontinence.

Phenolsulphonephthalein out put in two hours on admission, lowest 4%, highest 20%.

Urea nitrogen content, lowest 36 mg. per 100 c.c. of blood, and highest 100 mg. per 100 c.c.

Pathological report 9 cases were adenomatous, one adenocarcinoma.

It is clearly the duty of the general practitioner to attempt to make an early diagnosis in these cases and to educate the public both in the danger of delaying surgical interference to long and in the comparative safety of an early operation.

While it is true that many men do not consult a physician until compelled to do

so on account of complete retention, it is also true that many physicians do not appreciate the significance of the early symptoms and treat these cases with antispasmodics, urinary antiseptics and other palliative measures for a long time before referring them to a urologist. It is possible that the high mortality following a prostatectomy, until recent years, prejudiced the general practitioner against this operation; however today, with proper pre-operative preparation of the patients, our mortality is well under five per cent. and it is not unusual to read reports of hundreds of consecutive cases by different urologists with no mortality. Even in the advanced cases with chronic retention for years with renal insufficiency and cardio-vascular disease we have had no operative mortality in the past five years. That some of these cases will die within two or three years following the prostatectomy from some intercurrent disease must be expected, but the cause of death should not be attributed to the operation, but to one of the complications resulting from the long duration of the vesical obstruction.

It has been estimated that over fifty per cent. of all men over the age of sixty years suffer from prostatic hypertrophy, therefore we should consider all men above this age as potential prostatitics and a careful history and routine rectal examination should be made with that suspicion in mind, irrespective of the patient's subjective complaints; elderly men frequently consult a physician complaining of loss of appetite, drowsiness, headaches and other vague symptoms, not complaining at all of any bladder symptoms, yet a rectal examination will discover a large prostate and often we will find in addition a bladder extending almost up to the umbilicus; these men consider frequency of urination and straining as a natural sequence of age and do not complain about it. Obstructive prostatic hypertrophy should be suspected in all elderly men who complain of frequency, especially nocturnal, and when accompanied by a history of difficulty in starting the stream, straining and a large stream with no force behind it, a rectal examination will invariably find a large prostate; if in addition three or four ounces of residual urine is found a radical operation should be advised after excluding other pathology as stricture, stone and tabes.

The treatment of obstructive prostatic

hypertrophy in our opinion should be a radical prostatectomy as soon as the diagnosis is made; in the incipient stage conservatism invites disaster, prolongs the suffering and exposes the patient to infection and other complications which later marks him a poorer surgical risk; in advanced cases we never feel justified in condemning a patient to a catheter life, for no matter how toxic he may be drainage can be established and continued for weeks or months, if necessary, until the toxemia is relieved as shown by the blood chemistry, renal functional tests, and the general condition is sufficiently improved to make the prostatectomy a safe procedure.

Whether the operation is performed in one stage or two stage must necessarily depend upon the duration of the disease, the amount of residual urine, the renal sufficiency and the general condition of the patient. As practically all of our cases suffered from acute or chronic retention our routine is the two stage suprapubic method. Patients admitted with retention are not immediately catheterized and completely drained, for the sudden relief of back pressure may produce an acute congestion of the kidneys and loss of function followed by uremia and frequently death within a few days; we remove six to eight ounces of urine every three hours for a few days before performing a cystotomy.

The first stage a suprapubic cystotomy is done under a local anaesthetic with very little discomfort to the patient; a mushroom catheter is inserted into the bladder and the wound sutured; patients are encouraged to be out of bed as much as possible, and measures are taken to increase the elimination and tone up the cardio-vascular system; every few days tests of renal sufficiency are made; until quite recently most reliance was placed on the phenolsulphonephthalein out put and when the dye did not appear in the urine within twenty minutes and was less than thirty per cent. in two hours, patients were considered very poor surgical risks; we found, however, that occasionally patients with a low phenolsulphonephthalein out put show a normal blood urea nitrogen content and vice versa, we now place more reliance on the blood chemistry. As a rule, however, the amount of dye eliminated will increase and the excess of urea nitrogen will di-

minish and the physical condition will within two weeks improve sufficiently to warrant the removal of the gland. The second stage is performed under gas oxygen anaesthesia, the mushroom catheter is removed, the fistula is dilated sufficiently to admit two fingers, and with the aid of an assistant's finger in the rectum to elevate the prostate, the gland can usually be removed within a few minutes. Although hemorrhage following a prostatectomy is seldom very serious, we are convinced that it adds a good deal to the shock of the operation, we now invariably insert a Pilcher hemostatic bag, which effectually controls the bleeding and prevents the formation of large clots; traction on the bag is released within a few hours and the bag entirely removed in twenty-four hours; a right angle drain is then inserted and the free end connected with a bottle at the side of the bed. In about ten days the drain is removed, the patient is out of bed, and encouraged to void; from our last series the average time for the sinus to heal completely was 24 days.

It is not the object in presenting the subject before the members of this Society to write a technical paper on prostatic hypertrophy, but to impress upon the general practitioner, who sees these cases long before the urologist, the uselessness of palliation and the importance of recommending a radical operation before the development of serious complications.

88 Clinton Avenue.

Federal Hospital Census.—A recent announcement of the U. S. Department of Commerce states that on or about Jan. 1, 1923, there were 893,679 persons confined in "federal, state, city, county and private institutions for defectives, dependents, criminals and juvenile delinquents, homes for adults, homes for dependents and neglected children, institutions for juvenile delinquents, penal institutions and almshouses." The report shows a total of 783 institutions for the mentally diseased, feeble-minded, and epileptics, a total of 4,978 general hospitals, a total of 1,206 special hospitals, and a total of 289 federal hospitals in this country. There are, it states further, 2,519 general dispensaries and 87 industrial dispensaries. The report shows also that during 1922 there were 4,973,032 patients treated in hospitals and 21,621,761 visits of patients for treatment in general and special dispensaries.

CONSIDERATION OF FAMILIAL DISEASES OF LOCOMOTION.*

By **Alfred Gordon, M.D.,**
Philadelphia, Pa.

The term of "familial diseases" implies that certain pathological states repeat themselves in several members of the same family, run an identical course and develop independently of exterior causes. Therefore they do not include epidemic disease caused by micro-organisms which may affect members of the same family, such as acute anterior poliomyelitis or encephalitis lethargica. They do not include syphilitic disorders which may attack several children, but which were transmitted by the parents by virtue of an intra-uterine infection from an outside microbic agent. They do not include congenital anomalies resulting from general or local diseases of the foetus, which have their effect on the growth and development of the entire foetal organism or of a part of it. Familial disorders are disorders of the germ-plasm itself. The ova or the spermatozoides contain in themselves originally a latent morbid taint, which leads to the evolution of an abnormal type.

In presence of any given anomaly it is highly important to determine with precision whether it is morbid and the result of an accident in the life of the foetus, or else it is inherent and hereditary. In the first cases the damage is confined to the carrier of the anomaly and will no more be apt to be transmitted through heredity than any lesion which occurred in the extra-uterine life. In the second case, on the contrary, the affection is inherent and belongs to the group of etiological factors that are capable to exercise their influence on subsequent generations. Familial diseases therefore constitute a problem of heredity.

If one draws a parallel between disorders transmitted to the descendants, with those present in the ascendants, almost invariably a similarity in the form is found. For example, arrested development in the intellectual domain finds its source in an analogous condition of the ascendants. Various psychic disorders of the psychoneurotic individuals originate chiefly in a similar psychic heredity, demonstrating thus the existence of disturb-

ances of the same character in the ascendants. In physical heredity one observes a predisposition of an organic character, such as cerebral congestion, headaches, apoplectiform insults, cerebral fatigue, abnormal impressionability of the cerebral neurones to toxic factors, precocious senility by virtue of a specially transmitted power of cerebration. There are therefore substantial reasons to admit that heredity, generally speaking, is expressed by transmission of similarity, and more in the fundamentals of the latter than in its form. If sometimes we do observe dissimilarity of the transformation in heredity characteristic-units, we are dealing in reality only with apparent changes of form, but not of basic elements. The latter are the source of the cardinal heredity phenomena irrespective of their form. What is commonly called "predisposition" in morbid functions of a physical, intellectual moral, emotional or volitional domain, is the predominant feature transmitted directly by the fundamental psychopathic or physical disorders of the ascendants.

The most illustrative example of such occurrence we find in the familial diseases, since, as it was already mentioned, pathological conditions are observed in several members of the same family independently of all external causes.

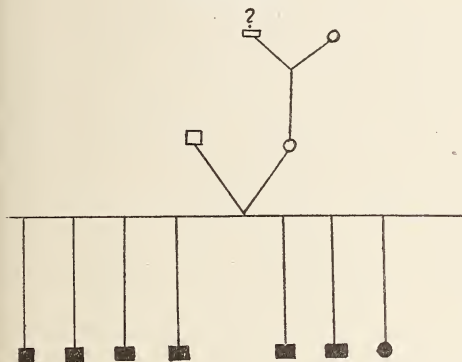
Myopathies, which were first described by Duchenne de Buglone in 1861, are a type of familial diseases. Cases have been described how a muscular dystrophy of facio-scapulo-humeral variety with its progressive invasion of the upper and lower extremities, also of the thorax, has been observed in brothers, sisters, and cousins. This same affection may appear in subsequent generations, either in the children of the affected individuals or even in the offspring of some brothers or sisters who happen to remain normal and escape the invasion of the defect. We are now in possession of facts showing that almost all apparatuses of organic life are susceptible of presenting disorders and lesions characteristic of familial diseases.

To Charcot and his pupils belongs the merit of observing a family character in some diseases of the cerebro-spinal system. Familial diseases of the locomotor system were the first studied and they are the best defined at present time. The best example of this group are found in Ataxia of Friederich's type and of Marie's type.

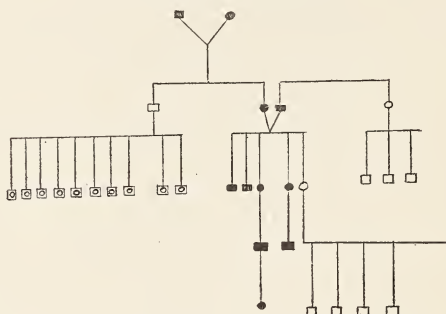
*Read at the Meeting of Eugenics Research Association, held at Cold Spring Harbor, Long Island, June 14, 1924.

GENEALOGICAL TABLES OF FAMILIAL DISEASES OF LOCOMOTION.

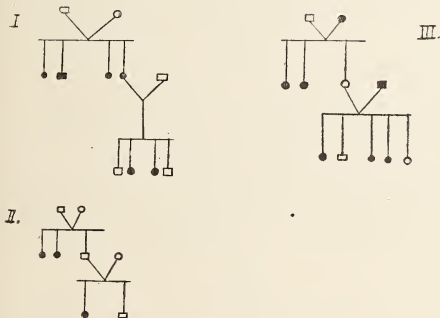
a. Familial Spastic. Paraplegia



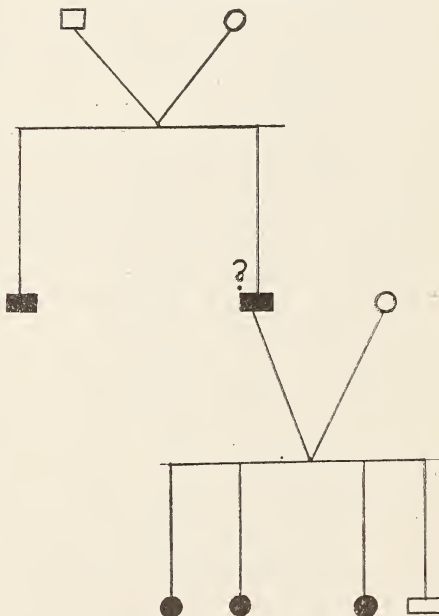
c. Familial Tremor.



b. Sydenham's Chorea (Familial.)



d. Familial Periodic Flaccid Paralysis.



Legends:

- Males affected
- Females affected
- Males normal
- Females normal
- ◻ Normal, sex unknown

Friederich's ataxia is characterized by inco-ordination of movements of the tabetic and cerebellar type, by choreiform muscula, instability, by intention tremor, loss of tendon reflexes nystagmus, and finally by deformities of the spine (scoliosis) also of toes, which are in hyperextension. Anatomically one finds a posterolateral sclerosis, atrophy of the cells of Clark's columns, of the direct cerebellar tract, of the antero-lateral tract and of the posterior roots.

This affection is familial, is observed in

some members of the same family irrespective of the sex.

In Marie's type one finds inco-ordination of movements of distinctly cerebellar type in the lower and upper extremities, intention tremor, disturbances of vision due to optic atrophy and contraction of the visual fields, increased tendon reflexes. Anatomically there is a manifest atrophy of the cerebellum especially of its lateral lobes, diminution of Purkinje cells, but there are no sclerotic or inflammatory lesions; the spinal cord as

well as the brain are intact. The family character of this disease is very striking. In Sanger-Brown's case for example five generations of one family investigated contained 55 persons, of whom 21 were affected. Not all generations were equally involved. It is interesting to note the variety of the ages at which the affection commenced to show itself in this case. The age of 46 was in the first generation, 40 in the second, 20 in the third, 14 in the fourth.

Familial atrophy of the cerebellum, as well as of the pons, medulla and cerebellar peduncles, without sclerosis, was observed by Bourneville and Crouzen. During life there is rigidity of all the four limbs and extremely low grade of mentality.

In Amaurotic Family Idiocy, besides the mental arrest and optic atrophy with the characteristic spot in the retina, there is also a spastic or flaccid paralysis of the extremities. The pyramidal cells of the cerebral cortex are more or less atrophied in this affection.

Muscular atrophy is another affection which may be encountered in several members of the same family. Although the classical interpretation distinguishes three types, viz: myelopathy, myopathy, and primary neuritic atrophy, nevertheless there are intermediary forms which partly belong to one or another group. A family character may be observed in any of the forms or groups of muscular atrophy. For example, in the case of primary neuritic type (Charco-Marie) record by Dubreuil, the mother and fifteen brothers and sisters were affected. In Dejerine's case the same type was observed in the grandfather, grandmother, mother, son and a brother of the mother; in Hoenel's case of the same type twenty-five persons in four generations were found. In this form the atrophy begins in the peroneal group of muscles and gradually gains the other extremities. The anatomical substratum is seen in atrophy of the peripheral nerves, degeneration of the posterior columns and of the cells of the anterior cornua.

Hoffman's form of muscular atrophy is seen in successive children of the same mother or father. It commences very early in infancy and particularly around the roots of the limbs. Gradually it keeps up its progressive course and when it invades the respiratory muscles, life is threatened.

Anatomically there is a destruction of the cells of the anterior cornua and degeneration of the anterior roots and peripheral nerves.

In myopathies the central nervous system as a rule is intact, but the muscular fasciculi are primarily undergoing atrophy, and the perifascicular connective tissue undergoes hypertrophic changes. Several members of the same family may be affected but the morbid type varies from one family to another and presents intermediary subvarieties. In the latter the atrophy may commence in different localities. Atrophy may affect some muscles always in the beginning of the morbid process, others in the course of the disease, while still others remain almost invariably intact. There seems to be a relationship between the precocity of muscular development and their predisposition to myopathy. Curiously enough, one observes in some families only the male members affected and the disease is transmitted solely by the women who themselves have presented muscular atrophy.

Atrophy is not the only muscular affection that disturbs locomotion.

Myotonia, myoclonia, chorea, tremors are the other disorders which are sometimes seen in some members of the same family.

Thomsen's disease or familial myotonia is, as well known, a disturbance of muscular function which consists of a sudden contraction of the muscles as soon as the individual makes a movement. The disorder is transitory, although it produces a temporary disability. The disorder is predominant in the the lower extremities, although it may occur in the upper ones and in other muscles, tongue and eye included. The affection is conspicuously familial in character. Thomsen himself suffered from it and he describes eleven cases in his family. Females are apparently exempt from this affection. The muscular force is diminished in spite of the fact that the muscles are hypertrophied. However, the development of the muscular fiber is incomplete, it remains in a state similar to an embryonic state. Evidently we are dealing with a familial disorder, manifesting itself in a defective development of muscular tissue.

Among other forms of familial disordered locomotion may be mentioned various muscular twitchings and contrac-

tions. Chorea, myoclonia, tremor are affections which may be encountered in members of the same family. The writer has a record of three families in whom quite a large number of members presented at various ages and in two generations episodic attacks of Sydenham's chorea. In Huntington's disease, which is a chronic form of chorea, the hereditary and familial character is typical. Here the affection makes its appearance in the middle age of life, affecting both sexes equally. It is progressive and terminates with an enfeeblement of the intellect and complete physical deterioration. The heredity character is direct and in the cases recorded in the literature it never missed one generation.

Tremors as distinguished from choreic movements may also be present in several members of the same family. There are in existence so-called families of tremblers. The morbid phenomenon commences at a certain age and increases as the individual advances. In Debove and Renaut's genealogical tree of one family both conjugal parties were tremblers. Almost all their descendants with very few exceptions were tremblers.

Spastic paralysis of the lower extremities with all the characteristic changes in the reflex action due to an atrophy of the pyramidal tract has been observed, first by Strumpel, in several members of the same family. Since then quite a number of similar records have been reported, either in the pure form or in a form intermediate between this affection and the heredocerebellar ataxia. The disease usually appears between fifteen and thirty years of age. In one family that came under my observation there were seven members affected with spastic paraplegia. Four of them began to show the spasticity at the age of three. Six of them were males and one a female. In families thus affected there is usually present some degenerative basis; either insanities, neuroses or alcoholism, consanguinity, syphilis. In the above case one paternal uncle was a paranoiac and a sister of the mother died at the age of 30 in dementia praecox. This type of the disease remains usually unchanged until the end of the patient's life, but sometimes, years after the onset, new symptoms develop and the picture of multiple sclerosis becomes apparent. In the family spastic paralysis we are dealing with a primary systemic degeneration of the pyramidal

tract as a result of a congenital malformation.

Oddo and Audibert in France, have called attention to a curious affection which is characterized by a periodic or intermittent loss of power in the extremities, mostly in the lower, and occurring in several members of the same family. The paralysis is sudden and occurs usually after a more or less prolonged period of muscular inactivity. It is flaccid in character and during the attack the affected muscles cannot contract on stimulation; electrical reactions are greatly diminished or totally abolished.

The writer had the opportunity of observing a family of four children, three of whom, all girls, and one uncle, brother of their father, suffered from intermittent attacks of complete loss of power in the limbs. The children's disability was confined to the arms, but the uncle's to the legs. Suddenly, without warning, and after an exertion they would be absolutely unable to move their limbs. The condition would last but 2 or 3 hours. During this period the tendon reflexes could not be obtained and the electrical contractility was much diminished to faradic and galvanic currents. Sensibility and intelligence were intact. In the intervals between the attacks the motility and muscular power were perfectly normal; the electrical contractility was normal and the reflexes were all present. In every other respect the four individuals were in good health. The father of these children told me that frequently, but not regularly, for many minutes at the time, he also would suddenly lose power in the hands. A vigorous rub brings the hands to normal. This condition occurs to him in the midst of perfect health and without feeling fatigued in any other part of the body. He evidently presented a form "fruste" of the same affection with which his children and his brother were afflicted.

Holtzapple reported a history of 17 individuals, distributed over four generations of the same family, who presented symptoms of periodic paralysis. The affection probably is due to a congenital defect of the muscular tissue, which under the influence of a physical effort is unable to contract to a degree sufficient to carry out the work assigned to it.

To sum up the present study of disorders of locomotion occurring in one family of one or several generations, we

must admit that the subject is one of structural anomalies created by evolutionary disturbances. They are variation from the architectural normal type. They create a predisposition which exists at the time of conception and is therefore transmitted to the product of the latter.

The knowledge of the laws of heredity and of the biological modifications which are the resultant of pathological modifications of the creating organism, is of paramount value from the standpoint of eugenics. Familial diseases or defects are governed by the general laws which are identical with those which regulate the transmission of normal morphological characteristics from the highest to the lowest point of the animal scale. Morbid heredity, as far as familial diseases are concerned, is controlled by the same laws as physiological heredity.

SOME PRACTICAL POINTS IN THE INSULIN AND DIETARY MAN- AGEMENT OF DIABETICS.*

By **Thomas Fitz-Hugh, Jr., A.M., M.D.,**
Instructor in Medicine, University of
Pennsylvania.

Diabetes mellitus is now firmly established as an endocrine disorder caused primarily by insufficiency of the internal secretion of the Islands of Langerhans of the pancreas. There is no need to review the history of our knowledge of diabetes. Suffice it to say that the discovery of insulin and its preparation in active non-toxic form by Banting and Best, and their associates at the University of Toronto, have completed the chain of proof as to the real nature of diabetes and have in addition given to us one of the most brilliantly effective and helpful therapeutic agents that has come to medical science in many years.

Owing to unfortunate and premature laypress notoriety, many misconceptions were broadcasted concerning insulin. Chief of these was that a *cure* for diabetes had been discovered, and secondly, that a diabetic need no longer undergo the privation of dietary restriction. As you all know, neither of these is true. Insulin is no more cure for diabetes than is food a cure for starvation. Both relieve, but both must be continually supplied to prevent relapse. Insulin simply furnishes the substance (lacking or deficient in a diabetic) which is necessary

for the internal combustion of carbohydrates and indirectly of other food substances. Just as a cretin must have a continuous supply of thyroid substance, so a diabetic must have continually supplied enough insulin to compensate for that which is deficient. Furthermore, as you will readily see, it is even more important for a person receiving insulin to have a carefully balanced diet than for one not receiving insulin. Insulin is a very potent substance which, when injected into the body of a given individual, "burns up" unit for unit a fairly constant amount of carbohydrate. The dose of insulin varies with the patient's deficiency and with his diet. If not enough is given, the patient remains a diabetic. If too much is given, the patient is thrown into a dangerous state of hypoglycemia in which the blood sugar level is reduced too low and alarming symptoms appear.

In the practical management of a diabetic with a view to the possible use of insulin, we have three major factors to consider in any given case: 1st, What is the carbohydrate capacity of the patient? Or in other words, how much carbohydrate can the patient utilize without raising his blood sugar level above normal without spilling over sugar in his urine? 2nd. Is such amount of carbohydrate, supplemented by the proper additions of fat and protein, enough to maintain the individual in a fairly normal state of nutrition and health without glycosuria and without ketonuria? 3rd, If not, then how much dietary increment must be effected and how much insulin must be given to obtain the desired result?

I shall now outline our method of approach in any given individual suspected of having diabetes—excluding for the time being those urgent cases who show unmistakable evidence of impending coma.

First, as to the urinary sugar test by reduction of copper solution. As you all know, there are other substances than glucose in the urine which reduce Fehling's solution. The same applies, though possibly to a less extent, to Benedict's solution. When in doubt, always do an yeast fermentation test. Furthermore, never make an absolute diagnosis on the basis of a single laboratory test. There are too many sources of error. As a matter of practical experience, we have found Fehling's solution about as generally satisfactory as any other and it is doubtless the one which most of us use. A good, "positive" reduction of Fehling's solution repeated once or twice a week to make doubly sure is almost certain evi-

*Read before the Burlington County Medical Society, Burlington, N. J., April 9, 1924.

dence of glycosuria. For quantitative estimation of urinary sugar, however, the Benedict's solution is preferable in general practice.

Having made the diagnosis of glycosuria, we must then proceed to determine its cause. True pancreatic diabetes usually gives rise to one or more of its well-known symptoms—polyuria, polydipsia, polyphagia, pruritus, furunculosis, pains in the legs, and a loss of weight usually following varying degrees of obesity. A patient who gives none of these symptoms and who nevertheless shows more or less constant glycosuria may or may not be a true mild diabetic. In diabetes mellitus there is invariably an increase in the urinary sugar following an increased sugar intake. Renal diabetes on the other hand shows a constant trace of sugar in the urine which is in no way influenced by diet. Furthermore, renal diabetes is in itself symptomless. If you have a patient, therefore, who is symptomless as regards the syndrome of diabetes mellitus and who shows constant traces of sugar in his urine not influenced by sugar intake, you may safely conclude that you are dealing with a case of renal diabetes, or at least not with true diabetes mellitus. Of course, a blood sugar tolerance test should be done to make absolutely sure. Above all, don't give insulin until you are sure you are dealing with diabetes mellitus.

Having made the diagnosis of diabetes mellitus, our next step is to estimate the patient's carbohydrate tolerance. There are a number of ways of doing this—all dependent absolutely on the patient's willingness to co-operate. I think the following is the simplest and most useful. Put the patient on one quart of whole cow's milk a day. Instruct him to take nothing except what you have ordered, namely, one quart of milk in half glass doses throughout the day, and absolutely nothing else except water. Now, as you all know, whole milk contains approximately four per cent. each of fat, protein, and carbohydrate. One liter (1,000 c. c.) is so little more than a quart (i. e., is 2.1 pints) that the difference is negligible. Therefore, one quart of milk furnishes forty gms. each of fat, protein and carbohydrate (i. e., one and one-third ounces). Now it is a very severe diabetic indeed who cannot handle 40 gms. of carbohydrate and a caloric intake of less than 700 calories, which is the value of a quart of whole milk. We shall consider these severe cases later, and for the present confine our attention to the more usual type, which invariably be-

comes free of urinary sugar on the above regime within a few days at most. Having "desugarized" the patient by this modified starvation method, we now increase the milk on-half pint daily until the twenty-four hour specimen again shows sugar. To illustrate by concrete example, suppose Mr. A's 24-hour urine specimen representing an intake of two quarts of milk shows no sugar, while the following 24-hour output representing an intake of two quarts plus one-half pint of milk shows a positive sugar test. What, then, is Mr. A's sugar tolerance? Obviously it is about 4 per cent. of two quarts, or 80 gm. of carbohydrate. (We will not complicate matters at this stage by considering the sugar contents of the protein and fat.) With this knowledge, together with a knowledge of Mr. A's weight, we are now in position to make the proper additions of protein and fat to furnish him his utmost safe diet.

First, as to protein: Authorities are agreed that one gram of protein per kilogram of body weight is ample for all bodily needs. That is approximately one-half gram of protein per pound of body weight (one kilo equals 2.2 lbs.) Suppose Mr. A weighs 150 lbs. We would give him, therefore, 75 gms. of protein daily.

Now as to fat: As is well known in diabetes mellitus, an excess of fat increases the processes that lead to ketosis or acidosis. How then can we determine the optimum amount of fat in any given case? Thanks to the research of Woodyatt and others, we have a reasonably accurate and simple formula for determining this factor as follows. The acidosis producing factors (ketogenic) of foods are those substances which, during metabolism, yield fatty acids or may yield fatty acids. These are 90 per cent. of the fat and 46 per cent. of the protein. The substances which combat and prevent this tendency (the antiketogenic factors) are those substances that contain available glucose. These are 100 per cent. of the carbohydrate and 58 per cent. of the protein and 10 per cent. of the fat. Now it has been determined that if the diet is so balanced that the sum of all the ketogenic factors is not more than one and one-half times the sum of the antiketogenic factors, there is complete combustion of the fatty acids, and hence there is no danger of acidosis. Let K equal the ketogenic substances and A equal the antiketogenic substances. Hence, if we keep our diet within the limits of the formula, K equals one and one-half times A , we shall be safe. An easy

approximation of this is the formula F equals $2C$ plus $0.5P$ where F equals Fat C equals carbohydrate P equals protein.

To return to the case of Mr. A whose protein requirements are 75 gms. and whose carbohydrate tolerance is 80 gms. daily. What is the highest safe fat intake that we may prescribe for him? Substituting in the formula, we have F equals 160 plus 38 equals 198 gms. fat (approximately 200). We, therefore, have Mr. A's optimum diet as follows: Protein, 75 gms.; fat, 200 gms.; and carbohydrate, 80 gms. Just what this prescription means in terms of slices of beef steak, eggs, cabbage and beans, we shall consider later on. Before we go to the trouble of making out Mr. A's daily menu, let us stop to consider if this diet is enough to maintain Mr. A in a fair state of strength and nutrition.

As you all know, the unit of food energy is the large calories—that is the amount of heat necessary to raise one kilogram of water one degree centigrade. The caloric value of food substances has been carefully worked out by several different methods and may be found in any book on diabetics. The figure representing the minimum energy requirements of a man at rest is about 25 calories per kilo of body weight (about 11 to 12 calories per pound). Our friend Mr. A, who weighs 150 pounds or approximately 70 kilos, will require as a low limit enough food to furnish 25 times 70 or 1,750 calories. If Mr. A does a day's work, his requirements are much greater—that is about 40 calories per kilo or 2,800 calories to maintain his normal state of nutrition.

How much energy is furnished by Mr. A's optimum diet containing 75 gms. of protein, 200 fat and 80 carbohydrate? A gram of protein yields 4 calories of heat energy, a gram of carbohydrate yields the same, while a gram of fat yields 9 calories when completely burned either inside or outside the body. Mr. A, therefore, would receive from 75 gms. of protein 300 calories, from his 80 gms. of carbohydrate 320 calories and from his 200 gms. of fat 1,800 calories, making a total caloric intake of 2,420 calories.

Obviously then, this diet would meet Mr. A's basal requirements. But if he had to work 12 hours a day for his living, this diet would probably be slow starvation. Assuming that Mr. A belonged to the so-called working class, what could we do for him? In the pre-insulin days, the problem was a hopeless one. Mr. A would slowly waste

away or would eat more than he could tolerate, and in either event the inevitable end would be coma and death or death from some intercurrent malady to which he would fall an easy prey. Now, with the aid of insulin, there would be little excuse for Mr. A ever dying of diabetes. We would simply give Mr. A a properly balanced diet which would furnish the necessary energy to maintain his strength and nutrition and give him daily enough insulin to enable him to utilize all his food in a normal way. What would such a diet be and how much insulin would have to be given?

We wish to give Mr. A about 2,800 calories. His protein requirements are well met by the 75 gms. (300 calories) previously determined. His carbohydrate would have to be raised to about 110 gms. daily (440 calories) and his fat to 250 gms. (2,250 calories). This would furnish 2,990 calories and if you stop to figure it out in terms of ketogenic-antiketogenic balance, you will find it safely within the Woodyatt ratio. Now as to the necessary insulin: This diet contains 30 gms. of carbohydrate in excess of his tolerance, and it is with carbohydrate excess that we are chiefly concerned in estimating insulin dosage—although as Allen and others have shown the total intake as determined by all three food elements, plays a part. In a general way we may say that one unit of insulin when injected into the human body will "burn up" from 1 to 4 gms. of carbohydrate. The exact amount varies in different individuals so that actually we begin with a small dose and work up gradually to that amount which finally controls the hyperglycemia and the glycosuria. We may say that for an average case one unit of insulin will account for two gms. of carbohydrate. On this basis Mr. A would require to burn up his 30 gms. excess carbohydrate from 10 to 20 units of insulin a day. We would first test him out for idiosyncrasy by giving him one unit. I have never seen such a case but they have been reported. Assuming that nothing happened, we would then give him 5 unit doses three times daily before meals, or that amount which just barely renders the urine free of sugar. Having then determined the proper amount of insulin, we would give it all in one or at most two doses—say 15 units before breakfast, which should be made a large meal. In this way Mr. A might go on indefinitely. He should certainly not die of diabetes.

Now a few practical points regarding the use of insulin. It must be given hypoder-

matically. Administration by any other route (except intravenously) is worthless. It must be given within 15 to 30 minutes before meals. If the meal is withheld after a dose of insulin, symptoms of undue lowering of the blood sugar will ensue. These symptoms of so-called hypoglycemia are sweating, weakness, nervousness, apprehension, tremulousness, muscular twitching, giddiness, visual disturbances, and finally a semi-comatose state that is clinically not unlike that directly opposite condition diabetic coma. In children and experimental animals convulsions may occur. (Cite cases of hypoglycemia).

The treatment of insulin shock, which is another name for this condition, is the immediate exhibition of some readily assimilable carbohydrate, such as sweetened orange juice or sugar. If the patient is unable to swallow, then give 10 per cent. glucose intravenously. In an emergency a dose of adrenalin by hypo will serve to mobilize the glycogen of the liver very quickly and tide the patient over until some carbohydrate food can be given. All patients receiving insulin must be instructed in the importance of prompt meals and in the symptoms of hypoglycemia and its treatment. We teach all our patients to administer their own insulin. The site of injection should be changed from day to day. any patient receiving insulin and indeed any diabetic, must be warned as to the dangers of gastro-intestinal upsets with diarrhea and vomiting, as well as the dangers of infection of all kinds from simple colds to in-growing toe nails and abscessed teeth. For all of these conditions have a marked influence upon the blood sugar contents and upon the sugar tolerance. A diabetic with this sort of trouble is in danger on the one hand of insulin shock, and on the other of acidosis, and should go to bed at once and send for a physician.

As you all know, only certain diabetics need insulin. In general, any diabetic who can be kept up within 5-10 pounds of his proper weight for his age and height and sex (as determined from any insurance table) by proper dietary regulation free of glycosuria and ketonuria, should not be given insulin. Insulin is to be given to the following groups of cases: 1. Diabetics whose sugar tolerance is so low that adequate diet cannot be attained without glycosuria and hyperglycemia. 2. Diabetics who become actually ill from any cause. 3. Diabetics with threatened coma or those in actual coma. 4. Those who have some

complication requiring surgical intervention. 5. Diabetics with chronic nephritis who have high renal threshold and hence hyperglycemia with symptoms of intractable itching, etc., not controlled by diet. 6. Diabetics with tuberculosis. 7. Juvenile diabetics.

The diagnosis of diabetic coma is as a rule not difficult. Of course a blood-sugar determination and a determination of the plasma carbon dioxide content are very satisfactory aids. But the alert and well trained physician needs only his clinical sense aided by a Fehling's test and a ferric chloride test for diacetic acid and possibly a catheter for collecting the necessary specimens to make the diagnosis. Patients in diabetic coma need plenty of carbohydrate, little or no fat and plenty of insulin. They require constant watching and frequent urinary tests. In short, they are best handled in the hospital. But if the physician is willing to devote his undivided time for some hours or days if need be and is equipped with the knowledge necessary to guide him in the administration of insulin, the case may be well treated at home. Here is is that insulin shows itself to be a veritable miracle worker. For impending coma or for actual coma, we recommend the following routine. (See Jonas and Musser American Journal Medical Sciences, April, 1924. p. 589.)

"Treatment of Threatening or Developed Coma. Provide a special nurse or attendant both day and night, preferably one trained in diabetic work.

Bed.—Keep the patient in bed and warm. Avoid loss of calories through exertion or exposure; if restless protect from becoming chilled by flannel nightclothes. Every effort should be made to allay nervousness and discomfort.

Bowels.—Move the bowels by one or more enemata. Cathartics should usually be avoided for fear of causing diarrhea.

Stomach.—This should be free from indigestible food. With adults, when in doubt, but with children in all cases, begin treatment with gastric lavage.

The Heart.—Sustain the circulation with the help of digitalis. Caffein may be given subcutaneously, or as black coffee by rectum.

Administration of Liquids.—Give 1,000 c.c. of liquids within each six hours. The liquids are to be given slowly, hot, as coffee, tea, thin broth, water. Give by mouth if possible 20 gm. of glucose and simultaneously hypodermically 20 to 50 units of in-

sulin. Continue giving glucose, 15 gm. every hour and insulin, 10 to 30 units, every third hour unless sugar disappears from the urine. If the patient is unconscious and cannot take glucose by mouth, give continuous enteroclysis of 5 per cent. glucose and give insulin hypodermically, as just described. Five per cent glucose containing 10 units of insulin per one pint may be given intravenously."

Before concluding let us consider a few matters of household diabetics. At the outset it must be said that a diabetic who has been under institutional management for a few weeks is better able to regulate his diet than one who has not. But this is not essential. If the physician is willing to learn the fundamentals of diabetic diatetics himself and will take time to impart his knowledge to the patient in simple form and convince him of its importance, excellent results are obtained. The patients should be taught to test their own urine for sugar and for diacetic acid. The weighing of food is advised at the start until the patient becomes familiar with the approximate volumes of different weights of food stuffs. For this purpose the special diatetic scales that weigh in grams are the simplest in the long run. Any physician treating diabetes must be familiar with certain food-values. One of the best practical little books of its kind that you can buy is Joslin's Manual. Another little book of inestimable value in converting grams and ounces of foods to terms of household measures is Locke's Table of Food Values. There is no short cut to this knowledge, although many helpful tables and ready made diet lists can be procured. They do not take the place of actual working knowledge of food stuffs. This knowledge once learned will repay you in a hundred ways, not only in the treatment of diabetes, but also the proper handling of all the metabolic disorders. It lifts such practice out of the realms of guess-work to the satisfying and pleasant level of an almost exact science. I shall now show you a sample of a very useful diatetic prescription for your patients with diabetes, and shall also show you a few sample diet lists of different diets for diabetics*

In conclusion I should like to emphasize four points:

1st. Search all diabetics carefully for food of infection and eradicate as far as possible any such that may be found. Infection of any kind from pulmonary tuber-

culosis to dental root abscesses greatly lowers sugar tolerance.

2nd. A diabetic must have good teeth. If his own are bad, get him some false ones as soon as possible. But don't build the foundations of your dental bridges in the dangerous quick-sands of pre-existing dental infection. Have a dental x-ray first.

3rd. Keep your diabetics slightly under weight.

4th. All you need as well trained physicians to treat diabetes is an easily acquired knowledge of the chemistry of the disease, and an equally easily acquired knowledge of practical diatetics, together with a few test tubes for the Fehling's and Gerhardt's tests and last but not most important of all, the character, judgment and personality that will enable you to command your patient's confidence and obedience.

*Samples of The Universal Diabetics Diet Lists planned by Dr. E. E. Cornwall, and put out by the Connell Press, Brooklyn, N. Y.

BIBLIOGRAPHY.

An Outline of a Routine for Insulin Therapy.—Leon Jones, M.D. and John H. Musseh, Jr., M.D.; American Journal Medical Science, CLXVIII., 4, April, 1924.

Management of the Diabetic Patient.—W. C. Stoner, M.D.; American Journal Medical Science, CLXVII., 2, Feb., 1924.

Clinical Reports.

A Case of Epidemic Encephalitis.

By Drs. J. M. Summerill and W. H. James.
J. M. S., aged twenty-four years, an exceptionally well-developed male, weighing about 170 pounds. Occupation, physical instructor at Rutgers College and a law student.

Chief Complaint.—Pain in right arm, nervousness, sleeplessness.

History of Present Illness.—Patient was enjoying good health until January 20, 1923, when he had a mild attack of influenza. He apparently recovered from this attack in about three days, but on January 24 was seized with a neuralgic pain throughout the entire length of his right arm; accompanied by extreme nervousness and an inability to sleep. By January 28 the pain in his right arm had subsided, but he still remained very nervous and could not sleep. On January 31 the pain had entirely disappeared from the right arm, but now appeared throughout the entire length of the left arm. In about three days the pain disappeared from his arm and now appeared in his shoulders posteriorly over the scapulae. At the same time the entire right abdomen became somewhat painful and tic-like spasms of the abdominal muscles on this side appeared. The patient began to have hallucinations at night, but did not have them in the daytime. He became progressively worse; choreiform movements of his arms and legs now appeared, but the neuralgic pains in the shoulders and arms subsided.

On February 7 he had an attack of syncope and fell outstretched across a bed—in about an hour he recovered from this attack.

On February 8 he had another attack of syncope, which lasted about one-half an hour. On February 10 the patient became more nervous than at any previous time, and in the afternoon had a series of epileptic convulsions, lasting for about an hour. The patient, during the convulsions, was in a semi-conscious state, exhibited Cheyne-Stokes breathing, hallucinations, no frothing at the mouth or rolling of the eyes, and at one period during the attack the pulse was not perceptible in the radial arteries for about one minute. The patient survived this attack and has had no attacks of syncope or convulsions since that time.

During his illness the patient could not lie in bed—it made him extremely nervous and uncomfortable—if allowed to sit in a chair he was more comfortable, and together with the administration of large quantities of bromides and some morphine was able to sleep about one to two hours in twenty-four hours. Since this date (February 10) the patient has very slowly improved—appears time, but at night is wide awake, very restless and has marked delirium. His temperature, the highest being 100.3-5 degrees, has returned gradually to normal; pulse, which ran from 110 to 126, has dropped to an average of about ninety per minute; respiratory rate coinciding proportionately with the pulse. While he has been very delirious at nighttime during his illness—at times requiring restraint—as soon as daylight appeared his mind became rational, only to return to delirium again, as night came on. The tic-like spasms in his right abdomen disappeared about February 17; the choreiform movements of the arms and legs have gradually subsided; the delirium has gradually lessened and finally disappeared March 12.

Throughout his illness, the patient has maintained his neck in a more or less flexed chest. The muscles of the neck have shown stiffness; the anterior muscles being in a state position, at times the chin resting on the mastoids. There is very little pain in the neck, and on massage the neck can be returned to normal position without much effort on the patient's part. There has been no Kernig's sign present, or headache at any time.

Since March 12, the patient has been able to lie in bed at nighttime for about two or three hours and sleep, but during his sleep, and also during the daytime, he would have spasmodic flexion of his arms and legs, with loss of consciousness. These attacks would last anywhere from a few minutes to an hour, and occur about three or four times in twenty-four hours. He has also developed some tickling sensations over the shoulders, both anteriorly and posteriorly; also some parasthesias of his arms and legs.

Throughout the illness he has had no gastro-intestinal disturbances, and a fairly good appetite. No ocular palsies, nystagmus, or diplopia, some dimness of vision at times. Has been able to walk at all times. Reflexes

have been present, both superficial and deep and apparently normal. Lumbar puncture was not done.

Etiology of Hemorrhagic Fluids in the Chest.—Dr. D. O'Hara, in the Boston Med. and Surg. Jour., says: I would like to briefly record a case which I think justifies the placing of syphilis in the differential diagnosis of this condition.

Mrs. C., 42, white, married, but not living with husband. Father and father's father both died of cancer. One brother dead, of "tumors." Mother and five siblings living and well. One son living, 21 years old, and well. No miscarriages. Past history negative, especially for questions regarding skin eruptions. For past five years had had cough and hoarseness in damp weather, but had always been able to work until one week before the time when she was first seen, May 18, 1923. She then complained of pain and distress in the left chest, and a slight, unproductive cough. She was a well developed and fairly nourished woman. Except for very evident signs of a large left pleural effusion, the physical examination was negative. A chest tap yielded a quart and a half of homogeneously bloody fluid. She was sent to the Waltham Hospital, and in the next three weeks four and a half quarts of fluid were removed from the chest. Her Wassermann reaction was positive. The diagnosis was primary sarcoma of the mediastinum, with tubercular pleurisy and intrathoracic syphilis as second and third choices respectively. The chest fluid was placed in a guinea pig and was centrifuged and stained for evidences of tumor cells by Dr. Mallory. No tumor cells were found. Six sputum examinations were negative for tuberculosis bacilli. The urine was negative and there was good kidney function. The x-ray, in addition to giving the usual picture of fluid, showed a displacement of the superior mediastinum and slight compression of the trachea at the level of the top of the sternum. The temperature ran from normal to 103.5. Iodides and mercury were given, but there was loss of weight and strength until the first of July. At that time Dr. Mallory reported the guinea pig test to be negative. Sarcoma was still the diagnosis, although the fluid was no longer reaccumulating with its previous rapidity and had become less hemorrhagic in character. Dr. Mallory's report placed tuberculosis in third place and moved syphilis up to second choice. It was then decided to start intensive anti-syphilitic treatment, which to the delight of everyone resulted in rapid improvement. She was discharged from the hospital, much improved, on August 18, 1923. Under treatment she has since remained well, and now has nothing to show for her "sarcoma" except slight dullness in the left back.

Cystin Calculi: A Complex Surgical Problem.

C. E. Tennant, Denver, in the Journal A. M. A., reports the case of a girl, aged 21, who had symptoms of distress (pain) in the right side, and some pains on urination. Finally she had an attack simulating appendicitis. A moderately actually inflamed appendix was removed, as well as twelve stones from the right ureter.

A stone was also found in the right kidney. Later, Roentgenograms of both kidneys and ureters were made, one stone being found in the left kidney and two in the right, with both ureters negative. At subsequent operations, all these stones were removed.

Followup Records of a Series of Patients With Bronchopneumonia.—Dr. Walter Lester Carr, of New York, stated that in 1919 there were 237 patients with bronchopneumonia admitted to the Pediatric Service of the City Hospital. Of this number 179 had bronchopneumonia and 8.5 per cent. of them died. Dr. Guilfooy, of the Department of Health, stated that in 1920 there were 2,384 deaths in New York from bronchopneumonia in children under two years of age, while in 1921 there were only 1,557. We could not give in percentage what proportion of the children who were ill with bronchopneumonia died, but the statistics of the Henry Street Settlement for 1920 give 1,377 cases of bronchopneumonia in children below two years cared for by visiting nurses, and of these 193 died, a percentage of 7.4. Assuming this mortality to be correct the mortality table of the Department of Health would show a disease incidence of the 17,000 cases for twelve months.

In a recent communication in the J. A. M. A., attention was directed to the importance of home care for children with bronchopneumonia and urging such treatment wherever possible. For comparison the article gave the mortality in acute bronchopneumonia as 117 of 282 cases in one institution, and twenty of forty-eight cases in another. These figures for home care and nursing seemed so unusually good for a disease so treacherous as bronchopneumonia that they led the writer to attempt to solve some discrepancies of the mortality of hospital patients under his own observation, both in the hospital and after leaving the institution. It was interesting in studying the mortality of a disease treated within a hospital or at home to compare the incidence of the disease not only by age, but by epidemic influence. For example, in the recent 1922 mild epidemic of influenza there were children with bronchopneumonia who did well in the hospital and patients in their homes recovered without a high mortality.

In private practice, children with measles, as the writer had observed them during the past few months, had not had bronchopneumonia as a fatal complication. Without a knowledge of bronchopneumonia and its average mortality we could not accept wholly this percentage of calculation of home care and mortality, especially as the statistics of the Henry Street Settlement by nurses in charge showed that about 10 per cent. of severe cases of bronchopneumonia were sent to hospitals and their calculations were misleading to this extent. Compared with a mortality of 7.4 per cent. in the children cared for by the Henry Street Settlement during an influenza epidemic was not excessive, nor was it especially favorable to visiting nurses, as during the year 8.5 per cent. of children under two years with bronchopneumonia were referred to hospitals by nurses. The complete figures of a followup series from the City Hospital

showed the advantage of checking up patients after they had left the hospital. Without intending to disparage the value of home nursing, comparison had been made with the Henry Street Settlement statistics to show that no one agency could completely determine the mortality of a disease like bronchopneumonia which in its association with epidemics and its close association with tuberculosis changes might give a low mortality rate in one calculation and a high one in another. To determine the results of hospital treatment in bronchopneumonia followup visits by social service workers and nurses from settlements should be made and patients should report back to hospitals for reexamination.—N. Y. Medical Journal.

Abstracts from Medical Journals

Fracture Pains.—Do not control the pain of fracture following the application of a splint by morphine. If the patient is having sufficient pain to require morphine you must assume that the splint has not been applied properly and is doing damage.—L. Beye in The Iowa State Med. Jour.

Radium. The total supply of radium in the United States, it is reported, is about 100 grams, most of which is owned by physicians. Rich deposits of radium having recently been found in the African Congo, the Radium Company of Colorado has closed its mines and is now an agent for the Congo supply, which, although richer than the Colorado supply, yields only 1 part of radium to 5,000,000 parts of ore.

Treatment of Carbuncle.—Dr. Edward L. Mitchell, Illinois M. J., has used treatment for carbuncle in a large number of cases with gratifying results, and from reports made to him by physicians to whom he has suggested his methods, he believes it to be of exceptional value. The treatment is as follows: Use a solution of permanganate of potassium in excess of saturation so as to carry particles of the chemical in suspension.

Use a syringe with a large caliber needle, avoid healthy tissue, introduce it through necrotic areas or pustular openings, wrap gauze around the needle, press it against the tumor, use some force so as to penetrate the entire mass. After-treatment: Dress it with gauze saturated with the same drug.

Radium Therapy of Cancer.—Arthur Burrows (British Medical Journal, July 8, 1922) asserts that the radium treatment of cancer is most complicated: The dose depending largely upon the changes occurring in the tumor as a result of its nature or position. The possibility of actually stimulating an outlying portion of the growth, which is radiated insufficiently, must be borne in mind. Before the absolute success with radium therapy is possible, a great many physical measurements of the different parts of the human body and of pathological growths and a complete investigation of the nature of the lethal dose for cancer cells are necessary. This information will give an approximate idea of the proper method

of treating tumors in different locations, although even then some insurmountable biological difficulties, such as the resistance of the organism as a whole and of the tissues locally to cancer, will require elucidation.

Even in inoperable cases, the author reports that 7.5 per cent. of all the cancer cases treated with radium the patients are alive and well after periods of two to seven years and that in many cases of carcinoma of the cervix uteri, breast, skin, lip, etc., the patients have been saved from death by radium; endotheliomata of the parotid gland and spindle-celled sarcomata show still more gratifying results. A great many palliative cures, short of absolute cures, have been seen, while in nonmalignant conditions, like exophthalmic goitre, Hodgkin's disease, keloid, cavernous and capillary nevi, the percentage of cures is high. Radium therapy is specific for excessive uterine hemorrhage and spring catarrh.

Treatment of Primary Inoperable Carcinoma of the Breast by Radiation: Report of 54 Cases from the Breast Clinic.—Drs. Burton James Lee and Ralph E. Herendeen, New York City, in Radiology. Recent reports call attention to the dangerous and sometimes fatal results from giving routinely the so-called 100 per cent., or carcinoma dose, to the tumor. Satisfactory regression can usually be accomplished by a fractional dose method of treatment. Careful physical and roentgenographic examination is necessary to determine the proper method of treatment. The inoperable cases comprise approximately two-thirds of the primary carcinomata of the breast. Routine biopsy for diagnostic purposes is unnecessary, and may result in dissemination of the disease. The roentgenographic picture of early chest metastasis is characteristic but is frequently not recognized. Radiation of bone metastases usually gives relief from pain. The type of radiation and the dosage to be employed can be determined only by a study of the individual patient. The dangers of over-radiation are generally under estimated. Treatment by radiation lengthens life and relieves suffering.

Surgical Treatment of Certain Puerperal Infections.—Puerperal infection, in brief, is simple wound infection, and should be on general surgical principles. The puerperal state confers no immunity but rather the reverse. All surgeons recognize the gravity of a neglected palmar abscess, or a wound received in operating or dissecting. Ear specialists long ago learned the vital importance of cleaning out, with ligation if necessary, the thrombosed internal jugular vein in case of lateral sinus infection due to disease of the mastoid; and there is certainly a striking similarity between an infected thrombus in the jugular and the same in the veins of the pelvis.—J. F. Baldwin: Am. J. Obst. & Gynec.

Fallacy of Pluriglandular Organotherapy.—The specious theory that we can supply the human body with any quantity or quality of endocrines, the internal co-ordination being so perfect that the body cells pick out only the kind and quantity of hormones needed, is not only without basis in demonstrated facts, but

is in some instances (as the thyroid, and possibly the hypophysis and pancreas) definitely contradicted. The fact that most of the endocrine products are more or less inert when taken by mouth probably explains much of the success of the pluriglandular therapy in the hands of the uncritical.—Carlson, A. J.: Proc. Inst. Med. Chicago.

New Serum Treatment of Pneumonia.

Discovery of a new treatment for pneumonia in the form of an improved serum which, he said, might reduce the death rate from this disease by twenty-five or possibly fifty per cent., was described by Dr. Lloyd D. Felton, assistant professor of preventive medicine at the Harvard Medical School, in an address at the New England Health Institute. Ninety thousand persons die of pneumonia each year, in this country, so that the life saving possibilities of the new treatment, if realized, would mean between 22,000 and 45,000 lives annually in this country alone.

The treatment, devised by Dr. Felton in connection with the work of the influenza commission of the Metropolitan Life Insurance Company, consisted, he said, of a method of precipitating and concentrating the anti-bodies in anti-pneumococcus serum. The original serum, which has been known for some time, was weak, he added, and the value of its use had been diminished by the fact it produced violent reactions in the form of chills, serum sickness and rashes. Dr. Felton said he had been able to eliminate the harmful substances from the serum, leaving only the protective elements. He did this first when making studies with carbon dioxide precipitant, noticing that a heavy precipitate was formed in the serum when it was diluted in plain water.

A white, fluffy substance which was produced, he found, carried with it only the helpful substances of the serum. This improved serum gave satisfactory results when tested on mice. After further refinements, some of the product was sent to clinicians at the Boston City Hospital and at hospitals in New York and Brooklyn. Dr. Felton said that encouraging results were noted in the cases where the new serum was tried in these hospitals on a total of about 120 cases of pneumonia. The injections, he said, were made into the veins, injections made under the skin having been found to have little protective power. The indications from preliminary tests, it was added, are that the treatment will be extended into all types of lobar pneumonia, as well as type 1.

Dr. Milton J. Rosenau, professor of preventive medicine and hygiene at the Harvard Medical School and chairman of the influenza commission, commenting on the discovery, said: "I believe a distinct advance has been made in the treatment of pneumonia. Before the final word can be said concerning the usefulness and also the limitations of this agent, much scientific work must be done and the experience of clinicians in different places, at all seasons of the year, must be collected and studied."

Think how unreasonable it is to expect you should make others in all particulars what you would have them to be; when you cannot so much as make yourself what you are sensible you ought to be.—Thomas A. Kempis.

Medical Society Meetings

CUMBERLAND COUNTY.

E. S. Corson, M. D., Reporter.

The society held the June meeting as the guests of Mr. Isaac L. Shoemaker, proprietor of the Shoemaker Dairies. An inspection of the dairies was made under the guidance of Mr. Shoemaker. He demonstrated the feed and process of mixing a balanced rations and the results obtained in the milk out put. The sanitary conditions and methods of caring for the stock were perfect and have resulted in a very low bacterial count in the certified milk.

After the inspection, the guests went to the Cumberland Hotel, where dinner was provided by Mr. Shoemaker. Here he explained his motives in establishing the dairies. An informal address was given by Mr. Jefferies of the Walker-Gordon Co. He reviewed the changes that had taken place in the production and care of milk since his company had been established by a few philanthropists. He produced statistics showing the beneficial results morbidity and mortality, as well as milk-born diseases among adults.

Atlantic City Hospital Staff.

By Dr. D. W. Scanlan.

The Atlantic City Hospital Staff heard the report by Dr. Wm. J. Carrington of his Gynecological Service. Dr. Carrington reported 61 admissions to this service; 53 operations, 29 of which were major and 24 of which were minor. The mortality was none. The service covers a period of four months. The doctor then reported, in detail, a case of Fibroid Tumor, which was transfused because of a very severe grade of anemia; improved, then operated upon and recovered. The second case reported was an Ectopic in which the blood from within the abdomen was replaced into the patient by intravenous injections. This case will be reported in detail at a later date.

A. M. A. Annual Meeting.

As was anticipated, both because of its central location and the fact that it is the home of the Association, the Chicago session was the biggest ever. It was equally as successful in other particulars. The registration was 7,668, which is 1,200 more than the largest previous registration. The A. M. A. Journal gives full reports of both the House of Delegates business proceedings and of the scientific sessions.

The Scientific Exhibit this year surpassed any previous one conducted by the Association. Several special exhibits were the means of conveying to those interested the latest advances in the fields of pathology and in the prevention and relief of heart disease. Commercial exhibitors were more than satisfied because of the large attendance and excellent arrangements.

The following officers were elected for the ensuing year: President-elect, Dr. W. D. Haggard of Nashville, Tennessee; Vice-President, Dr. E. B. McDaniel of Portland, Oregon; Secretary, Dr. Olin West (Tennessee); Treasurer, Dr. Austin A. Hayden, Chicago; Speaker of the House of Delegates, Dr. Frederick C. Warnshuis of Michigan; Vice-Speaker, Dr. Rock

Sleyster, Wauwatosa, Wisconsin; Trustees, Drs. W. H. Walsh of Illinois, Edward B. Heckel of Pennsylvania, and Thomas McDavitt of Minnesota.

The next annual session will be held in Atlantic City, New Jersey, providing suitable arrangements can be made for hotel accommodations. The whole matter is left with the Board of Trustees. If satisfactory hotel and other arrangements cannot be made in Atlantic City for the accommodations required, the Trustees are authorized to select either Atlanta, Georgia, or St. Paul, Minnesota—or to go elsewhere, if necessary. It has happened that hotels, particularly, have not carried out promises made to the local profession when invitations were extended and before decision was arrived at. The Trustees were requested to make announcement of the time and place of meeting within sixty days after adjournment of the annual session.

Invitation to American Physicians.—This Association is supervising an Inter-State Post Graduate Clinic Tour to Canada, British Isles and France, to start May 18, 1925. Leading teachers and clinicians of Canada and Europe will arrange and conduct clinics and demonstrations in the following clinic cities: Toronto and Montreal, Canada; London, Liverpool, Leeds, Manchester and Newcastle, England; Edinburgh and Glasgow, Scotland; Dublin and Belfast, Ireland; Paris, Lyon and Strasburg, France. Besides the main tour, special tours to practically all the leading centers of Europe will be arranged. Sight-seeing trips to all places of interest in the countries visited will be included in the regular tour. Cost of tour, including first-class hotels, board, steamship, clinic arrangements and all ordinary traveling expenses, under \$1,000.00. The tour is open to physicians in good standing in their State Societies, their families and friends who are not physicians. For information, write the Managing-Director, William B. Peck, Freeport, Ill.

Error in Report of Dr. Park's Address.

We thank the Citizens' Reference Bureau for calling our attention to the error which we hasten to correct by inserting the secretary's letter. We endeavored to get Dr. Park's review of proof but failed to reach him and we are sorry to say that the hasty review made did not detect error.

Dear Doctor:—Permit me to direct your attention to an error which in some way got into the article by Dr. William H. Park in the Journal for July, 1924. On page 213 Dr. Park is quoted as saying:

"In New York City, due to the general diphtheria propaganda and toxin-antitoxin immunization, in the last five years diphtheria has dropped more than 5,000 in deaths and more than 40 per cent. in cases. That is a pretty big drop. Five years ago we had 12,406 deaths, last year 576."

The monthly bulletin of the Department of Health, City of New York, gives the number of deaths from diphtheria for the past five years as follows: 1919, 1239; 1920, 1045; 1921, 891; 1922, 873; 1923, 553.—H. B. Anderson, secretary.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

CHAS. D. BENNETT, M. D., Chm., 750 Broad Street, Newark.

EDITOR:

DAVID C. ENGLISH, M.D.,
P. O. Box 83, New Brunswick

ASSOCIATE EDITORS:

CHRISTOPHER C. BELING, M.D., Newark
HENRY B. COSTILL, M.D., Trenton
JAMES HUNTER, JR., M.D., Westville
HARRISON S. MARTLAND, M.D., Newark
FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

OFFICIAL TRANSACTIONS.

The Editor, after consultation with the chairman of the Publication Committee and the Secretary of the Society, decided to print the Transactions of the 158th Annual Meeting of our Society at Haddon Hall, Atlantic City, in a separate issue and not in the regular issue of the Journal. This is a return to our former method and we believe preferable, especially as it required several more pages than usual.

OUR MEMBERS' VACATIONS.

We congratulate the many members of our Society who were able to enjoy their annual summer vacations. The reports that have reached us have almost universally recorded unusually enjoyable and helpful seasons of rest. A larger number than usual sojourned abroad and many of them have not yet returned.

The Editor's only regret, concerning his annual vacation spent in Maine, is that it was not half long enough—only two weeks. More doctors from New Jersey were there than ever before and their number is in-

creasing each year. Journal work brought us home to find that work was hindered by the absence of many of our members, on their vacations, whose papers or discussions presented at the annual meeting needed revision, and it was therefore difficult to prepare the September issue.

OUR SOCIETY'S NEEDS.

We are decidedly of the opinion that the greatest need of the Medical Society of New Jersey is that our county societies' officers shall more fully realize that their election did not mean a mere conferring of honor, but a call for active and efficient service that shall raise the standards of the profession and make our State Society more honored as it shall better serve the public.

The Secretaries of the County Societies should observe the notice at the end of the List of "Presidents, Secretaries, and Reporters of County Societies" at the bottom of page xxiv. of the Journal. They should also correct, where needed, the date of their society's organization and times of their society's meetings, especially of the annual meeting, as these are given in the Official List at the head of each society's list of members. It is very important that those lists shall be accurate.

The Reporters should send to the Editor of the Journal an account of every meeting of their respective societies with a copy of papers read at the meetings that are of special value and would be helpful to our readers. Where such papers are sent for publication there should not be lengthy outlines of them given in the reports. Then they should send reports for our "Personal Notes" columns, of special interest concerning their members, especially notice of the death of any member with brief obituary notes. It is a matter of deep regret to the Editor, that he received no notes of the death of Dr. D. T. Millsbaugh of the Riverlawn Sanatorium, which occurred on June 27th, until after our August Journal went to press. Most of our personal notes have been gathered from the newspapers, and even some death notices. *This ought not to be the case.* They should come direct from our reporters.

We will not at this time dwell on the great need of largely increased attendance at our County Society meetings, but refer to one of the causes which should have speedy correction—holding them at places and at hours when it requires sacrifice to attend, e. g. at the extreme end of a large

county called to order at 8.45 P. M. Is it surprizing that the attendance averages only about one-sixth of a large membership?

An exchange journal we receive says: "Does your church pay you a cash monthly dividend? Does your golf club or your social club pay you a cash monthly dividend? No. And neither will your county medical society. You get out of either of them just about what you put into them, but the medical society that you actively help to be successful is a bigger contributor to your success than either of the other two."

A. M. A. CONFERENCE.

The Conference of Secretaries called by the A. M. A. and which met in Chicago last November was an occasion of great interest and we believe of great value in advancing the welfare of the organized profession. There is no doubt that the A. M. A. was wise in inviting the Editors of the Associations' Journals who were not state secretaries, to attend that conference. The two officers are closely related in Association work and the meetnig last year resulted in making the work of both better defined, more helpful to each other and more effective in service.

We received last April a letter from Dr. F. L. Van Sickle, Executive Secretary and Editor of the Pennsylvania State Society, in which he said:

"I wrote to Dr. Olin West, Secretary of the A. M. A., asking his advice as to whether some action should be taken by the non-secretary editors in the House of Delegates to make financial provision for our attending the Secretaries' Conference, and he advised me to write to those editors who are not state secretaries for their opinion. I was rather disappointed at the conference of editors last year in that no definite step was taken toward some sort of an organization which might make plans for the future, and inasmuch as the matter of program was left with Dr. West and myself, may I ask if you are in sympathy with the movement to have the A. M. A. trustees invite the editors who are not secretaries to the conference under the same conditions as existed with the state secretaries? Will you also make some suggestions as to the type of program you think should be presented next fall, suggesting some subject for discussion?"

Being in entire sympathy with the movement suggested, we wrote to Dr. West, as suggested, and received the following reply:

Dr. David C. English, Editor.

Journal of Medical Society of N. J.:

My dear Doctor—It gives me genuine pleasure to be able to inform you that the Board of Trustees of the American Medical Association has acted favorably on the suggestion that the Editors of Journals of State Medical Associations, who are not also secretaries of their re-

spective societies, shall be invited to attend and participate in the work of the annual conference of secretaries of constituent State Medical Associations, and that their necessary traveling expenses incurred in attendance of this conference shall be paid by the American Medical Association.

The date of the conference for this year has not yet been determined upon, but you will be promptly advised as soon as this matter has been settled. I sincerely hope that we shall have the pleasure of having you present at the conference.

Very truly yours,

Olin West, Secretary,

American Medical Association.

We believe the conference this year will be better attended and accomplish more good than that of last year, and we are quite sure that an organization of the editors—as we suggested last year, will be effected and will result in increasing the value of our Journals, the efficiency of our Associations and the advancement of our profession in all that tends to promote the public's health interests and humanity's welfare.

DR. GEORGE T. WELCH.

We deeply regret that we are again called upon to record the death of an ex-president of our State Society, Dr. Welch of Passaic, an event of special sadness because it was the result of an auto accident. Dr. Welch presided at our 1892 annual meeting, when he presented an address entitled "Many Drugs, Few Remedies," which was printed in many medical journals, and elicited several letters of approval, one of which was from the poet-actor, Oliver Wendell Holmes. He was a man of considerable intellectual ability and wrote many critical essays on literary subjects, also several poems which were printed in newspapers and magazines.

PROGRESS IN MEDICAL EDUCATION.

During the last twenty-four years, medical education in the United States has been extensively improved, so that graduates now obtain a medical training in accordance with the greatly enlarged present-day knowledge of medicine. A large oversupply of medical schools including many which were of low type, has been replaced by half as many greatly improved, well-equipped institutions. The number of medical students was reduced from 28,142 in 1924 to 12,930 in 1919, but the number in the better equipped colleges was increased from 4 per cent. to 88 per cent. Since 1919, also, these better trained students have been increasing at the rate of more than a thousand each year, the

total enrolment this year being 17,728, of whom 95 per cent. are in Class A medical schools. During the twenty-four years, the number of graduates from medical schools was decreased from 5,747 in 1904, of whom only 369 were from the better colleges, to 2,656 in 1919, of whom 94 per cent. were from the better equipped institutions. Since 1919, with the exception of the war class which graduated in 1922, the numbers graduating each year have been rapidly increasing. This year there were 3,562 graduates, of whom 94 per cent. were from the better equipped colleges.

Graduate Medical Education.

Three complete inspections have been made of all graduate and postgraduate medical schools, these being completed in 1916, 1920 and 1923. Based on these inspections, the "Principles Regarding Graduate Medical Education" were prepared and in June, 1923, were adopted by the American Medical Association. Last year, a list of fifteen approved graduate medical schools was published. This year, the number has been increased to forty-four. Attention is particularly called, however, to the series of subjects showing under each of the institutions in which approved courses of instruction are being offered. This information will be of assistance to physicians desiring to obtain graduate work in those subjects. The list at present is not large, but other subjects and institutions will be added as rapidly as they are investigated and found worthy of approval.—A. M. A. Journal.

DON'T STUDY MEDICINE GERMAN DOCTOR URGE.

According to the associated press correspondence from Leipsic, May 27th, the German Physicians' Association says Don't Study Medicine is the advice given the prospective students for the reason that for years to come the medical profession will be overcrowded.

One reason assigned is the fact that old doctors find themselves unable to retire from active practice, since their savings were wiped out by the depreciation of the mark, other reasons assigned of the loss of the colonies, the disarmament of Germany, and the poverty of the masses, who will not call a doctor except in the most necessary cases.

The most important reason of all is the fact that under the compulsory health insurance of Germany doctors are unable to make sufficient money to pay expenses. Recent figures show that at present members

of the profession are unable to make what represents \$5.00 per month in American money.—Illinois Med Jour.

HEROES OF WAR AND PEACE.

Several years ago when Dr. Charles H. Mayo read a paper before the Providence Medical Association, he stated that it was remarkable that so many statues had been erected in this world to Generals who had been associated with the destruction of life, but so few monuments to members of the medical profession who had devoted their energies to saving life. This is a strange commentary upon human nature and the primitive desire to land a fight which exists in every boy and man. This idea is not entirely new to the medical profession, but it is rather surprising to find the same idea expressed by a layman in the daily press recently. This was expressed in a letter to the New York Times, in which the writer felt that more praise should be given to physicians and surgeons who had been instrumental in saving life. Incidentally, he asked readers of his letter to name the ten leading physicians of the last century. We feel that such a task would prove a stumbling block to many of our own profession, to say nothing of submitting the problem to the laity. This is a fitting subject for a prize contest, and we invite suggestions and contributions from our readers.—Rhode Island Med. Jour.

BURIAL.

The London Medical Press and Circular comments editorially and with slightly elegaic touch on the custom of burial. Food for thought is found in a visit to a large London cemetery, studded with enough marble to fill a quarry. In any large city the question of burial must be a serious one; in a city of the age of London this wasteful use of land must present many complications. We are bound by tradition in the disposal of our dead more, perhaps, than in any other of our terrestrial activities. When will we come to realize the waste of space and the waste of money in our efforts to perpetuate as long as possible that for which the laws of nature have prescribed return to dust?

The acceptance of cremation has been slow; it should be swift and universal. The painful costly pomp of funeral ceremony is a relic of the darker ages of man's intellectual outlook. It is a pitiful effort to hold that which has gone. Can we not

recognize that if man lives after death he lives in the spirit, not in the body, and that the body without the spirit is not man?

"Were we to realize," says The Medical Press, "how a few centuries have sufficed to obliterate all evidence of the resting-place of the great majority of those who have gone before, we should more readily content ourselves with the assurance that the record of a life well-spent is inscribed on pages other than marble."—*Boston Med. and Surg. Jour.*

REST FOR THE TUBERCULOUS.

Our attention has been called to the fact that one of the illustrations appearing in the May number of *Hygeia* might convey a wrong impression. This illustration, which appeared over the caption, "Walks 7,000 Miles," is of a young man who is said to have had tuberculosis and who walked 7,000 miles via Canada to Los Angeles and gained 38 pounds.

If persons afflicted with active tuberculosis were to gain the impression from this picture that such vigorous exercise is to be advised, it would be unfortunate, indeed. The tubercular process in this young man had, undoubtedly, ceased to be active before he started on his long hike and, therefore, the daily tramp was proper exercise for him and the out-of-door life which it involved was greatly to his advantage.

It cannot be too strongly stated that when the tubercular condition is at all active rest is the most essential feature of treatment.—*Boston Med. & Surg. Jour.*

BUSINESS MEN AND MEDICINE.

Business men who are interested in the conduct of business in conformity with ethical principles have founded organizations in order to discuss problems common to different departments of commercial life. One organization under the name of The Rotary Club seeks to enroll representatives of the more important mercantile establishments in a given community and branches of this body are to be found in most municipalities. In addition to questions affecting the immediate interests of its members Rotary Clubs seem desirous of obtaining information relating to general civic questions, hence professional men are often asked to address these meetings.

The Somerville, Mass., Rotary Club secured Dr. Charles E. Mongan as speaker for the meeting held July first. Dr.

Mongan took occasion to inform his audience of the principles actuating the medical profession in its attempt to secure legislation which would protect the people from unreliable doctors. After interpreting the features of the law governing the registration of physicians, he carefully explained the underlying principles in this act which are to protect the people from the dangers incident to incompetent medical practice. It was made clear that there is no intent, actual or implied, in the statutes to create a medical oligarchy, but rather a fair and reasonable standard with which all who practice the healing art must comply.

Taking the present attempt to secure the enactment of a bill which would give to chiropractors special privileges as an illustration, he showed the dangers of such legislation and made it clear that the medical profession does not hold itself responsible for or against the application of any therapeutic measure, but that it does contend that before the right to practice is conferred all physicians should demonstrate adequate knowledge of the underlying sciences on which medicine is founded and sufficient training to make it reasonably sure that the practitioner may correctly diagnose the disease of the patient. The irrational and unjust class legislation that would give to one group the right to practice after a short and incomplete study of certain symptoms are contrasted with the pre-medical study and scientific instruction of the regular medical student was forcibly presented.

The members of the Club showed definite interest in the facts and arguments presented and it was evident that even this very intelligent body of men was not previously well informed as to the importance of the questions now before the public. This evidence of interest is encouraging.

Another Rotary Club has applied to the Editor of the Journal for a speaker who may be willing to talk on the relation of medicine to the public needs. Ignorance of the real attitude of the profession has often created prejudice. When the people have understanding they will fight their own battles. Our function is to present the truth.

The legal aphorism "caveat emptor" should be applied in the selection of a physician as well as in the trading places.—*Boston Med. & Surg. Jour.*

THE MIRROR.

After all, it is good for us to take our measure and to appreciate the defects. The physician, in this age more than others, must keep in touch with the public, and must explain his activities and frequently his motives. Medicine is no longer the personal thing of attending men and women in their beds; it is the severe business of imposing quarantine, preventing epidemics, and urging legislation.

This is sometimes a thankless task, for the service is rendered to a public that is taught to read and write, but not to evaluate. If the doctor cures a child of diphtheria, he is practicing personal medicine and is god. But if he prevents diphtheria, he is practicing public health, and may be a devil. Which means, paradox notwithstanding, that while the physician has kept touch with his patients, the profession has lost touch with the public.—Colorado Medicine.

BUREAU OF VENERAL DISEASE CONTROL

Trenton, N. J., August 7, 1924.

To the Physicians of New Jersey.

Dear Doctor: Each year the practicing physicians of New Jersey are reporting a large number of cases of venereal disease in which the name and address of the probable source of infection is noted. Through this information, professional prostitutes and sexually promiscuous women infected with a venereal disease are located and placed under supervised medical treatment. There are still some physicians who, apparently, do not appreciate the importance of obtaining this information for us. The value of this information and the damage which may result from the neglect to report cases promptly to the State Department of Health is illustrated in the following case:

Recently the health officer of a residential town in Union County learned, quite by accident, of a number of cases of gonorrhea among school boys in his town. He began an immediate investigation and located more than twelve cases. He interviewed these boys and men and found that they had been infected by a prostitute operating in a so-called road house some distance from the city. He learned that one of the first boys to be infected went to a physician in an adjacent city for medical treatment. The health officer turned the information over to the State Department of Health, and it was found that the physician concerned had neglected to report the case. If the physician had asked the boy where he received his infection—as the law provides—the boy says that he would have told him willingly. If the information had been obtained and given upon the report to the State Department of Health, prompt action would have been taken and many of the other gonorrheal infections might have been prevented.

If you have neglected to obtain this information in the past, will you not make a de-

termined effort to get it in the future. We need your help, and the work certainly deserves your support.

Respectfully yours,

A. J. Casselman, M.D., A. A. Surgeon,
Consultant, Bureau V. D. Control.

Report of Board of Trustees.

The Trustees met in Haddon Hall at 1 P. M. June 6, 1924. Chairman Sproul presided.

The resolution referred to the Board by the House of Delegates which would allow the Secretary of the Society to employ a paid assistant was discussed and adopted, and it was decided that the amount to be paid said assistant should not exceed eight hundred dollars without sanction of the Board of Trustees hereafter.

Another resolution referred by the House of Delegates, in favor of University Extension Graduate Medical Education in New Jersey, after favorable consideration, was, on motion, referred to the Welfare Committee for its action.

The following bills referred to the Trustees were, on motion, approved and ordered paid. Bill of the Judicial Council for expenses incurred \$137; bill of the Orange Publishing Co. for reprints of Dr. Sherman's Report, \$8.00

The Board then adjourned.

David C. English, Secretary.

Meeting of the Fellows.—The Fellows met in Haddon Hall June 5th at 12.30 P. M. Dr. Sproul was elected chairman.

On motion Drs. H. B. Costill, C. R. P. Fisher, Alexander Marcy, Walter B. Johnson and N. L. Wilson were elected as members of the Society's Committee on Nominations.

Miscellaneous Items

Infantile Paralysis.

Remember that you should suspect infantile paralysis if your child is ailing and any of the following conditions are present:

1. Cries when held or seems to have tenderness or pain in the neck and back.
2. Has a little fever and is drowsy.
3. Has fever and is very irritable.
4. Has a second attack of light fever coming on in a few days without known cause.
5. Shows sudden weakness in one or both legs or in an arm of both, a few days after fever.
6. Has been near any person who has infantile paralysis and shortly after gets a light fever.
7. Has diarrhea with slight fever.

If so, call your doctor at once!

Excerpts from the Chicago Department of Health Weekly Bulletin.

Since 1900 the death rate from Bright's disease has increased 15 per cent.; from disease of the heart, 27 per cent.

These are the diseases of adult life—the diseases of hurry and worry and overeating and nervous wear and tear.

As a matter of fact, the decrease in the death rate is due to the better care of infants.

The Failing Heart.—Paul W. White, Boston

Medical and Surgical Journal, says with regard to the treatment of anginal failure: "Rest is essential, mental and dietetic, as well as physical. Nitroglycerine or amyl nitrite are, of course, invaluable and should always be carried by the patient suffering from heart pain of the anginal type. Morphine should be given freely if necessary; when much of it is necessary coronary thrombosis is probably the underlying condition. Digitalis is generally contraindicated in the anginal type, of heart failure, but may help a good deal if the heart pain is due to right ventricular fatigue in mitral stenosis, or to the left ventricular fatigue in chronic hypertension. A light diet, particularly light in bulk, is of great importance; quantity is much more vital than quality. Five small meals a day, with the last one the lightest, forms a good program. Avoidance of taxing business cares as well as absolute omission of abruptness in physical activity, must be advised. Rest will not only cause the cessation often of anginal pains, but incidentally is by far the best treatment for hypertension, which may or may not be associated with the angina. As low a blood pressure at 115 mm. systolic has been met with in marked coronary sclerosis. If syphilis is proved or likely, antileptic treatment, begun with care, may be very beneficial."

Sudden Deaths Associated with the Injection Foreign Substances.

Dr. R. W. Lamson in the Journal of American Medical Association for April 5, has received the cases of sudden death from serum therapy. This is an important contribution and should be carefully considered as a means of relieving fears that have been entertained as to the danger of such injections.

Gottstein gives a brief summary of twelve fatal cases. Rosenau and Anderson have collected from the literature nineteen cases. Gillette from the literature, including unpublished cases, sixteen cases. The three references gives a total of thirty-seven cases. Reviewing foreign material of these reported cases, Dr. Lamson states, "This number is, of course, grossly incorrect, and, a careful study of the literature to date indicates many duplications of reported cases, as well as numerous instances in which death obviously was not due to the injection of the foreign material."

Park found that of the large number of cases treated with diphtheria antitoxin, there was one death for every 70,000 persons injected. These statistics were based on about 350,000 persons treated with serum. Following these statistics, Dr. Lamson analyzes the cases reported of sudden death and presents certain comparisons with other accidents which occur in the practice of medicine and surgery. —Iowa State Med. Jour.

Our Costly Glands!

The recent attempt in Chicago to convict the ductless glands of the body of responsibility for criminal tendencies in human beings has opened a new field of thought for the average person who hitherto reckoned crime, in the main, as largely due to two causes—lack of proper moral training in youth and of self-control. There are those who still think undue emphasis has been laid on the part played in

misconduct by these little-understood secretors of vital fluids, and it may be that when science has come to a clearer knowledge of their functioning this view will be justified. Meantime, of course, every person accused of crime, who can afford the services of expert endocrinologists, may seek mitigation of sentence on the ground of abnormal or subnormal glands.

Meantime, also, those who pause to consider the cost of crime to this country will be forced to conclude that these same ductless glands are about the most wasteful things in the world if, as alleged, they determine human conduct. And when we speak of cost in this matter, we do not include the incalculable value of lives lost through murder or criminal carelessness, or anything but the actual money expense of crime—the dollars it takes from honest folks; the dollars required for police protection and court and prison maintenance, and the dollars lost through industrial wastage caused by crime. To set this sum at the enormous figure of \$1,000,000 an hour, day and night, the year 'round, may seem reckless, yet according to recent statistics carefully collected from reliable sources, this is a conservative estimate. Ten billion dollars a year—nearly \$125,000,000 more than the aggregate of the sum just mentioned—is the figure named by a man who has spent much time on the subject. * * *

If our ductless glands are at the root of such a situation, it is obviously a matter of the utmost importance that every effort be made to learn about them, so they may be controlled in such a manner as to decrease their costly harvest of wrongdoing. Medical science should attack the situation with will, seeking definite knowledge in place of the misty theories which now mask the facts, whatever they are. Meantime, more insistence on discipline of children, the home on the school; more education in the line of personal mortality and self-control, and a vigorous administration of laws that mete punishment, regardless of the social or financial status of the offender, may do much to better the situation. There are matters of fact that can be proved by innumerable personal exhibits.—North American, Phila., Aug. 26th.

Both Forget.

Patient—I can't pay that bill. It's too much.
Medic—Well, I'll show you that I'm a good sport. I'm going to forget half that bill.

Patient—That's fine. I certainly appreciate that favor, Doc, and to show you what kind of a sport I am, I'll tell you what I'll do.

Medic—What's that?

Patient—Forget the other half.

It is not learning, grace, nor gear,

Nor easy meat and drink,

But bitter pinch of pain and fear

That makes creation think.

—Rudyard Kipling.

Get rid of your regrets. You are what you are on account of what you have experienced. And rightly understood, and accepted, all experiences are good, and the bitter ones best of all. I feel sorry for the souls who have not suffered.—Elbert Hubbard.

Coins Cleaner Than Paper Money.—Coins are much more sanitary than paper money, a recent study made by a German bacteriologist discloses. On a bank not which had been in circulation for some time and subjected to frequent handling as many as 143,000 bacteria were discovered. Metallic coins showed a much smaller bacteria count. Coined money is less harmful because its smooth surface does not accumulate bacteria and because of the specific germicidal action of the metal itself.

That all too common practice of allowing children to put coins in their mouths is, of course, greatly to be condemned, for the chances of infection are great.

The Cancer Cure.

From the N. Y. Tribune.

The forecast by a physician so eminent as Dr. Charles H. Mayo of a cancer cure "within a few years" is important medical news. Dr. Mayo, to be sure, qualified his assurance at the opening of the city's Cancer Institute clinic with the proviso "if we can centralize efforts." He said, however, that knowledge enough is already at hand to lead to discovery of an effective treatment, probably by American physicians.

It must be noted that Dr. Mayo, while hopeful of a cure, does not say that the problem of prevention will soon be answered. The key to the origin of cancer is still to be discovered. Whether it is to be accounted for by diet or by some unidentified factor of civilized life is quite uncertain. Whether it is or is not a bacterial disease has not been determined. Dr. William J. Mayo has said that chronic irritation is the great underlying cause. His brother suggests that over-eating in general is the probable explanation. There are a score of other theories. The cause of cancer is the great mystery of medicine.

The problem of treatment has been solved partially. Cancer is curable by surgery while it is a local growth. All surgeons give warning of the supreme necessity of removing cancer in the early stage. The weight of medical testimony as to the x-ray and radium treatments is that they are effective in the milder forms of cancer. Their value in some inoperable cases has been demonstrated.

Dr. Mayo intimates that the cure which he predicts may be accomplished through radium or x-ray or by a serum. He must have a specific train of thought on the subject or he would hardly have spoken so confidently. It is encouraging to be told by high authority that the specialists are on the right track in their systematic researches for the control of the "arch enemy of middle life and beyond."

The Passing of the General Practitioner.

The unfortunate individual who, by reason of the obscurity of his symptoms, is sent from one specialist to another often looks in vain for the only one who can interpret, weigh the value of and fit in place the seemingly unrelated parts of the puzzle: the well-equipped, broad-visioned, experienced general practitioner—the humanizer, as some one has fittingly expressed it, of medical practice. With his disappearance, except in some of our rural communities, disappears also that cher-

ished, often sacred, relationship between the doctor and patient—the personal side of practice.—Pharmaceutical Advance.

"It is the duty of the specialist to lend his aid in unravelling the tangled threads of diagnosis, to contribute his skill in the surgical requirements of the case, and, as soon as possible, to return the patient to his home, under the care of his family physician. Thus an undue expense to the patient is avoided, and thus the family physician is reinstated in the case, so that he can receive for his services his own proper reward, and thus the specialist is relieved of unnecessary details and allowed more opportunity to extend his real usefulness over a wider and more fruitful field of labor. In fact, the essence of the remedy consists in utilizing to the fullest extent the personal service of the family physician, and in minimizing, as far as possible, the individual attention of the specialist. The remedy consists in returning to the family physician a large part of the medical treatment which has unnecessarily been discharged by the specialist. Let each receive his own remuneration for his own labor, but let the specialist do less, and the family physician more."—McReynolds, Texas, M. J.

A Consumption Preventive?

The high repute of Professor Albert Calmette, of the Pasteur Institute, gives weight to his report to the Academy of Medicine in Paris of successful experiments with an anti-tuberculosis vaccine. The announcement by this leading disciple of Pasteur that the culture named "B C G" has proved to all appearances to immunize children not infected with tuberculosis is medical news of importance.

Eminent French physicians last winter issued a warning against tuberculosis "cures," stating that "there exists at the present time no medicine, either chemical or biological, no serum or vaccine, whose efficacy against tuberculosis has been demonstrated." If Professor Calmette's vaccine is as effective as he believes this assertion must be qualified. The new inoculation, however, does not cure; it is a preventive agent solely.

It is essential that the person vaccinated be free of tubercular infection. Since more than 90 per cent. of adults are, or have been, so infected, few except infants can be susceptible to the benefits of the vaccine. Moreover the subjects of the experiment in its present stage must be revaccinated year by year to insure immunity. Hope should not be too sanguine. Years will be needed, as Professor Calmette himself points out, to demonstrate the certain value of the safeguard. Yet the full implication of the discovery is that tuberculosis may eventually be controlled as effectually as smallpox by the vaccination of infants.

Meanwhile the sure preventives of consumption are well understood—fresh air, wholesome food, proper hygiene, healthful living conditions. Education in these regards has reduced the disease. In the city the death rate from tuberculosis has fallen 65 per cent. in the last twenty-five years. But it cannot too often be repeated that specific "cures" for consumption are worse than useless.

Operation to End Cancer Pain.

An operation for the relief of pain in persons suffering from incurable forms of cancer is the accomplishment of Dr. William G. Spiller and Dr. Charles H. Frazier, neuro-surgeons of the University Hospital. Only recently the perfected method of the operation, known as "chordotomy," whereby the sensory nerves are severed in the spinal column, has been made known to the Philadelphia Neurological Society. Dr. Spiller and Dr. Frazier have published the results of their experience with eight operations for the American Neurological Association, to be preserved in the archives of the Neurology and Psychiatry Association.

The operation is performed in selected cases where the distress of the patient is so great that drugs cannot alleviate it. According to Dr. Spiller, while the operation will not be entirely successful in every case in which it is employed, since some pain fibers occasionally will escape the knife, it has been performed successfully in numerous cases.

Triumphs of the university surgeon in making possible an operation to relieve the pain of those doomed eventually to death has been declared by Philadelphia physicians to be a notable achievement. The operation is "a delicate procedure," according to Dr. Spiller, and it is not to be undertaken by one untrained in the surgery of the spinal cords. It requires on the part of the operator a visualization of the microscopic anatomy of the cord and a realization that a slight misplacement of the incision may cause motor-paralysis of one or both of the lower limbs." In six of eight cases where the operation was performed pain was ended.

Special instruments for performing the operation have been invented by the surgeons.

Irrespective of the curing of cancer, the

—N. Y. Tribune, Feb. 29th.

Hospitals; Sanatoriums

Bergen County Hospital.—This hospital for communicable diseases has recently issued its annual report for 1923. It shows: total admissions 377, of which 113 were for tuberculosis cases, and 264 for contagious diseases. Of the latter there were 145 scarlet fever, 80 diphtheria and 2 smallpox cases.

Beth Israel Hospital, Newark.—The board of directors of this hospital announced to the Newark Conference of Jewish Charities that an audit of the recent campaign for a new building for the hospital shows that \$1,845,607.20 was raised, or \$345,607 more than the amount expected.

Although the campaign for funds closed June 9, contributions are still being received. \$5,000 was recently received from a theatrical ticket broker of New York.

Camden Municipal Hospital.—Seven cases of smallpox have recently been treated in this hospital, one of whom, a child, died.

Rahway Hospital.—An ordinance was passed by the Rahway City Commission recently creating the office of bacteriologist at \$1,500 salary with quarters and sustenance furnished. He is

under the control of the Board of Health and the Rahway Hospital. The hospital will provide quarters and sustenance and a laboratory and the city will pay the salary. All of the tests necessary in health work will be made at home instead of sending materials to Trenton.

Bonnie Burn Sanatorium.—Dr. John E. Runnells, superintendent, reports as follows: On June 30th there were 277 patients in the Sanatorium, 155 males and 122 females. This included 96 children in the preventorium. Since the last report 49 patients have been admitted, 23 males and 26 females. Twenty-nine of these admissions went to the preventorium. The admissions are classified as follows: Pre-tubercular, 29; incipient, 1; moderately advanced, 5; far advanced, 14. The largest number of patients present at any time during the month has been 278. Smallest number, 263. Present July 31st, 267. This number includes 98 children in the preventorium and 92 out of the county patients.

The following shows the condition of patients discharged during the month: Not considered, 2; quiescent, 5; improved, 27; unimproved, 8; died, 18. Total, 60.

Marriage.

CASSELMAN-BOYD.—At Rochester, Minn., July 21, 1924, Dr. Arthur J. Casselman of Camden, N. J., to Miss Lulu May Boyd of Rochester, Minn.

Deaths.

CORNWELL.—At Bridgeton Hospital, August 4th, Dr. W. Leslie Cornwell of Bridgeton, following an operation for appendicitis, aged 41 years.

Dr. Cornwell graduated from Jefferson Medical College, Philadelphia, in 1906, and was one of the most successful physicians in Bridgeton. He was a former captain in the medical corps; an officer in the Shoemaker Post of the American Legion, a firing squad of whose members fired over his grave after burial in respect to his memory. He was a member of the Cumberland County and State Medical Societies.

LAMPSON.—In Jersey City, N. J., August 25th, 1924, Dr. Mortimer Lampson. Further notice will be given next month.

MILLSPAUGH.—At Princess Anne, Md., June 27, 1924, Dr. Daniel T. Millspaugh of Paterson, N. J., aged 68 years. He graduated from the Medical Department of the University of the City of New York, 1884; member of the American Psychiatric Association; proprietor and medical director of the River-lawn Sanatorium.

WELCH.—In the Barnert Memorial Hospital, Paterson, N. J., on August 25, 1924, Dr. George T. Welch of Passaic. His death being the result of injuries received when his auto was struck by a train on a grade crossing of the Susquehanna Railroad.

Dr. Welch was born in 1845; graduated from the University of Pennsylvania in 1863.

He practiced in Keyport before settling in Passaic in 1889. He was a member of the Passaic County and State Medical Societies and a Fellow of the A. M. A. He was President of the Medical Society of New Jersey in 1892-3. He was the first president of St. Mary's Hospital in Passaic. Further notice will appear later.

MEDICAL EXAMINING BOARDS' REPORTS

	Exam.	Passed.	Fail'd
California, February ...	5	4	1
Colorado, April	8	4	4
Connecticut, March	27	19	8
Dist. Columbia, April ...	8	6	2
Maine, March	14	14	0
Massachusetts, March ...	48	28	20
Nevada, May	3	3	0
New Hampshire, March...	2	2	0
Illinois, April	7	3	4
Porto Rico, March	3	2	1
Wyoming, February	2	2	0
Hawaii, April	5	4	1
Rhode Island, April	7	6	1

Public Health Items.

Naught to Record.—The deputy health officer of a certain village (in Indiana) in responding to a letter of inquiry from the State Registrar as to why no birth or death report had been received from his jurisdiction, said: "We have not had a death in eleven months and we have not had a birth in the past year. Our people are too old to breed and too contrary to die."—Bulletin Indiana State Board of Health.

New Jersey Mortality Report.—During the month ending June 30 last, 3083 deaths were reported to the Bureau of Vital Statistics of the State Department of Health. Included in this number were 113 deaths of non-residents, leaving a total of 2970 resident deaths.

Rabies in New Jersey.—The State Laboratory of Hygiene at Trenton made 42 examinations of dog heads for evidence of rabies during the months of April, May and June. Positive results were reported as follows: April-12, May-19, June-11. These figures added to those of the first three months of the year give a total of 83 dogs shown by examinations made at the State Laboratory to have been rabid. This figure is much higher than the total number of positive examinations made by the Laboratory during the whole year of 1923. Figures furnished by the Newark City Laboratory and the Hudson County Laboratory show corresponding increases.

Elements of Success in Securing Enactment of Health Legislation.—Constitutionality, clearness and machinery of enforcement are the three elements on which the success or failure of every act depends. The time and thought expended at this point on any piece of proposed legislation is invariably amply rewarded after the bill becomes public property, and is presented to the legislature for consideration. Poor preparation and faulty draftsmanship have often delayed the enactment of necessary health legislation, and as

a result have postponed for many years improvements in public health conditions.—R. G. Paterson: Hosp. Soc. Serv.

Life Insurance Companies Interested in Venereal Disease Control.

Life insurance companies are vitally interested in the health of their policy holders, for a prolonged life means an additional number of premiums and deferring of the time when the principal must be paid. Some companies have inaugurated an active health campaign among their policy holders, and also have employed workers who devote their entire attention to instructing policy holders how to keep well.

One of the greatest causes of disability and premature death is the venereal diseases and yet because of the stigma formerly attached to these diseases, the insurance companies have been slow to have their social workers undertake the responsibility of active work in this field. That they are beginning to appreciate the need for spreading information regarding gonorrhea and syphilis and the necessity for using the same methods for the control of these diseases as have been found successful with other communicable diseases was shown recently when one of the largest companies had 350 of its social welfare workers in New York City attend a lecture on "The Control of Venereal Diseases," illustrated with eight reels of motion pictures. The lecture was given by Mr. Maurice G. Ricker, Assistant Director of Educational Work of the United States Public Health Service—N. Y. State Dep't of Health.

Hospitalization of Syphilitics.—What should be done with patients in the infectious stages of gonorrhea or syphilis who can not be cared for properly in their homes? The frequent receipt by this department of letters similar in character to that given below indicates the need for an early solution of this problem.

"Dear Sir:—Can you tell me where I can secure hospitalization for a syphilitic child in the infectious stage? I have such a child under observation at the present time and so far have been unable to find any hospital where he could receive care.—Probation Officer."

A majority of the small hospitals refuse admittance to cases of syphilis and gonorrhea while in the infectious stage, although in most instances they do not refuse to admit them when they are suffering with later complications. Even municipalities maintaining wards in private hospitals are not always able to hospitalize venereally infected vagrants who come into their hands. Patients have frequently been sent to the nearest House of the Good Shepherd and other correctional institutions not so much because of their waywardness as for the purpose of securing hospitalization for them in their homeless condition. This method is not above criticism because it reflects upon the character of the patient; yet it is frequently found to be the best solution so far as the protection of the public is concerned. Admission to these institutions, however, is denied to children under 16 years of age and adults over 35. In one state we are informed that the health officials have met the problem by setting aside certain cells in the county prison for hospital purposes. Patients are committed to

these rooms under a law that permits the health officer to select the place and character of isolation for patients infected with a venereal disease in the communicable stage.—Health News, N. Y. Health Dep't.

Report of International Health Board.

The International Health Board of the Rockefeller Foundation, in 1923, co-operated with government agencies in health work in sixty-eight states and countries. The report of the general director, Dr. Frederick F. Russell, shows that the board's activities included the development of rural health organizations; the world-wide campaign against hookworm disease; a campaign against yellow fever in Mexico, Brazil, Colombia and other countries of Central and South America; co-operation in the health program of the League of Nations; the organization of facilities for training public health nurses in France, Brazil and the Philippines; the training of other public health personnel through schools of hygiene and fellowships; the development of public health laboratories, and field studies in malaria control in the United States and various tropical regions. Dr. Russell says that the International Health Board does not feel that any demonstration has been successful unless its assistance ceases to be needed within a reasonable time, and that any project which is not absorbed into the official health service is obviously unsuited to the time or place. The report states that there were 230 counties in twenty-eight states of the United States that had full-time health organizations, and that in Ohio 48 per cent. of the counties had full-time organizations; Alabama, 32 per cent.; North Carolina, 31 per cent.; New Mexico, 27 per cent.; South Carolina, 21 per cent., and Georgia, 11 per cent. Only two years have elapsed in Brazil since the first full-time health unit started, but county health units are being established in several states. The government has co-operated with sixteen of the twenty states, and 225 projects are under way.

When several hundred cases of yellow fever were reported at Bucaramanga, Colombia, the board sent experts, on invitation from the Colombian government, to confirm the diagnosis and to institute control measures. New cases of yellow fever rapidly ceased to appear, and none have been reported since May, 1923. There was a serious epidemic in Ceara, Brazil, from 1921 to 1923, and the disease has been endemic in Bahia, where a total of 157 cases was reported, with thirty-nine deaths. The board assisted in developing nine laboratories in seven states in 1923. A laboratory was opened in Honduras; Costa Rica is ready to establish one; in Nicaragua, a laboratory was conducted by a native staff throughout the year, and two branches have been opened; and in Salvador the work of the laboratory has been extended to include the examination of foods and drugs. Manila, Dr. Russell says, has long had the distinction of having one of the earliest and best equipped diagnostic laboratories anywhere in the world.

The campaign against malaria in the southern part of the United States started in 1917 and about the army camps, and after the armistice this work stopped. It had been a war measure carried on regardless of expense, and

the hesitation of small communities to undertake to keep this work up was easily understood. The International Health Board was able to show that malaria control need not be expensive, but that an average community can virtually rid itself of malaria at a per capita cost of from 45 cents to \$1 a year, provided a careful preliminary survey is made to define the local problem. During the year the board's malaria control work was carried out on a county basis, and whenever possible the campaign was directed by the county health officer with the assistance of the state health officer. During 1923, seventeen new counties undertook antimalaria campaigns. The spleen index was shown to be a simple and reliable index of malaria. In Lee County, Georgia, a comparison of the spleen index, plasmodium index and the malaria history index of 571 persons examined, showed that the spleen index furnished a more sensitive measure of malaria than the blood index. Among these people the spleen index was 40.8 per cent., the plasmodium index 25.2, and the malaria history index 37.4.

The board co-operated with governments in twenty countries in the control of hookworm and treatment was administered to 717,000 persons under the direction of the board's representatives. In Ceylon alone 500,00 outpatients were treated for hookworm in 240 institutions. On the average, in all the twenty countries, 80 per cent. of the persons examined were found to be infected.

Personal Notes

Drs. Gordon K. Dickinson of Jersey City, George H. McFadden of Hackensack and Berthold S. Pollak of Secaucus have been traveling together through Europe. They attended the 4th Congress of the International Union Against Tuberculosis held in Lausanne. Dr. Pollak discussed the paper of Prof. Forsner of Stockholm, on "The Relationship Between Pregnancy and Tuberculosis," and also Sir Robert Phillips of Edinburgh paper on "The Effect of the Anti-Tuberculosis Campaigns on the Diminution of the Tuberculosis Mortality in the Different Countries."

Dr. Frederick W. Owen, Morristown, spent the month of August at Lake Minnewaska.

Dr. Edgar A. Ill, Newark, has been appointed, by Mayor Breidenbach, a member of the Board of Education in place of Dudley Farland, resigned.

Dr. Robert J. Donnelly, Newark, and wife recently took a trip to the Great Lakes.

Dr. Julius Levy, Newark, recently returned from Europe, where he attended a conference on child hygiene in London, and also visited the Berlin hospitals.

Dr. Edgar W. Lane, Bloomsbury, spent several weeks in North Carolina.

Dr. Carl H. Wintsch, Newark, and wife spent three weeks on a motor trip to Maine. They visited friends of Westville, who have an island in Damariscotta Bay.

Dr. Alexander MacAlister, Camden, is enjoying his trip abroad. He was deeply interested in his sojourn in Rome.

Continued on page xxii.

On the main line of the Lehigh Valley and the Central Railroad of New Jersey. Three and one-half hours from Philadelphia. Four hours from New York. Eight hours from Buffalo. One hour from Wilkes-Barre.

SUNNYREST SANATORIUM

White Haven, Pa.

A Private Sanatorium for Incipient Cases of Tuberculosis

LOCATED high in the Blue Mountains of Pennsylvania, 1,300 feet above sea level, you have at your very doorstep the best of the delightful scenery of a region noted for its natural beauty and healthful climate.

There are both cottages and individual bungalows. All rooms are private.

For patients on exercise, there is a centrally-located dining-room. Bed patients are served by competent maids. There is an experienced *chef* with a natural appreciation for good and wholesome food.

There are modern facilities for the most advanced methods of treatment. There are specially trained graduate nurses always in attendance.

Patients with a natural appreciation for comfort, service and amusement, will find Sunnyrest a delightful place. For those on exercise, there is a newly finished miniature outdoor golf course with all the thrills and hazards of a full-length course. There are wide

verandas and comfortable chairs. There are charming walks through woods of spruce and pine and oak.

Patients are under the direct medical supervision of the following well-known physicians: Drs. H. R. M. Landis, Joseph Walsh, Frank A. Craig, Isadore Kaufman, Elmer H. Funk, all of Philadelphia, and Dr. Alex. Armstrong of White Haven.

Terms for private room in Cottages: \$30.00, \$32.50, \$35.00 and \$40.00 per week. Terms for individual bungalows with private bath and dressing-room: \$45.00, \$50.00, and \$60.00 per week. This includes everything but Medical Fees.

Reservations are now being made. For particulars, address:

IVAN F. GOODRICH, Gen'l Manager

Sunnyrest Sanatorium (East Side) White Haven, Pa

Orange Publishing Company

Printers, Publishers
and Stationers

14 So. Day Street,
Orange, N. J.

Mutual Pharmaceutical Company

INCORPORATED

MANUFACTURING PHARMACEUTISTS

OWNED AND OPERATED
BY AND FOR PHYSICIANS

*Hundreds of Physicians Testify
to the Reliability of our Prod-
ucts and Money Saved on
Purchases.* :- :- :-

LET US ADD YOUR NAME TO OUR
MAILING LIST

Syracuse

New York

PERSONAL NOTES.

Continued from page 306.

Dr. William H. Arenson, Montclair, and family spent the month of August at Agunquit, Maine.

Drs. W. P. Glendon and Ray Siimkins Bridgeton, spent a week in July at Chincoteague, Va.

Dr. Elbert S. Corson, Bridgeton, and wife visited Cleveland and vicinity in July.

Dr. Millard F. Sewall, Bridgeton, and family attended the 25th reunion of his class in Dartmouth College, N. H.

Dr. Leslie Cornwell, Bridgeton, and family occupied a cottage at Avalon, N. J., in July.

Dr. Earl C. Lyons, Bridgeton, and family recently spent two weeks at Mrs. Lyons' former home in Phoenixville, Pa.

Dr. Herbert H. Wilson, Bridgeton, and daughter accompanied the Kiwanis delegates to Denver, Col., and returned via Niagara Falls.

Dr. John B. Casale, Newark, and wife motored to Atlantic City the latter part of July and returned August 4th.

Dr. J. Henry Clark, Newark, and wife spent six weeks at Ogunquit, Maine.

Dr. Morris H. Leaver, Quakertown, spent two weeks recently at Carlisle, Pa.

Dr. James R. Irwin, Belleville, and wife spent a three weeks' vacation in Maine.

Dr. William P. Thorne, Butler, and wife spent ten weeks in Canada.

Dr. Linus W. Bagg, Newark, wife and daughter have been enjoying a month's vacation at Lake Ontario.

Dr. Alvin Lippard, Hillside, enjoyed a two weeks' vacation recently to Asbury Park and Atlantic City.

Dr. Saul M. Rubinow, Newark, and wife took a two week trip to the Adirondacks and Canada last month.

Dr. Henry B. Kessler, Newark, and wife spent two weeks last month in the Adirondacks.

Dr. Louis Schneider, Newark, and wife took a motor trip to Buffalo last month and cruised on the Great Lakes.

Dr. William Klein, New Brunswick, spent two weeks in the Adirondacks last month.

Dr. Charles F. Abraham, East Orange, recently returned from his visit to Block Island, R. I.

Dr. Lancelot Ely, Somerville, spent August at his camp at Bangor, Pa.

Dr. Charles E. Teeter, Newark, wife and son are spending their vacation at Bailey Island, Me.

Dr. F. M. Hoffman, New Brunswick, and family spent the month of August at the New Monmouth, Spring Lake.

Dr. Theodore B. Fulper, Hampton, and wife spent a week at Asbury Park last month.

Dr. Charles J. Sullivan, New Brunswick, and family occupied a cottage at Spring Lake during August.

OFFICIAL TRANSACTIONS

58th Annual Meeting of the Medical Society of New Jersey

Held at Atlantic City, N. J., June 5th to 7th, 1924

HOUSE OF DELEGATES.

Thursday Morning, June 5, 1924.

The One Hundred and Fifty-eighth Annual Meeting of the House of Delegates convened in Haddon Hall, Atlantic City, N. J., at 10 o'clock A. M., Dr. Wells P. Eagleton, President, in the chair.

President Eagleton: The meeting will come to order. We will be led in prayer by Rev. Dr. Hinson V. Howlett of Atlantic City. Dr. Howlett offered the invocation.

President Eagleton: We will now hear from Dr. Clarence L. Andrews, President of the Atlantic County Medical Society.

Dr. C. L. Andrews: Mr. President, Members of the New Jersey State Medical Society, Ladies and Gentlemen: It gives me very great pleasure as President of the Atlantic County Medical Society to welcome you to Atlantic City. I believe I can say that with great emphasis today because of the unusual circumstances which surround it. One year ago it was my pleasure to welcome you here and today in the same capacity, from the same platform, I greet you again. This singular honor may have been the good fortune of some one else before. However, it struck me as certainly not having happened often, at least. Atlantic County Medical Society is the youngest in age of any county except Ocean County, having been formed June, 1880, one month after Salem was organized. We have one hundred and eleven active members and meet each month as you know except during June, July, August and September. We put forth every effort to obtain the best men possible to get on our programs and usually have a good attendance.

In Atlantic City we almost have an annual post-graduate course in that so many representative conventions meet here. Last year we had nine and this year so far six. There are two chief things which have always been of interest to me: First—it does not matter what type of meeting one attends, he learns something, even if it is an x-ray convention and he is an internist; secondly—our local men attend the State convention in greater numbers than the other conventions. It cannot be because of

the type, as the others are of the best and have men of national fame connected with them; it must be some particular interest in the State Society alone that prompts them to do it. Last year the State Society had one of its best meetings and this year it should be even better. We are always glad to have you meet here and each member will take great pleasure in trying to make your visit a success.

President Eagleton: The report of the Committee on Credentials by Dr. W. J. Carrington, will be presented later. The next number on the program is Reading of the Minutes of the 1923 meeting.

Secretary Morrison: The minutes of the 1923 meeting having been published in our Journal in the October issue, I move that they be accepted as the minutes of the meeting, and that the reading of them be dispensed with. The motion was carried.

President Eagleton: We will now hear a report in the Permanent Delegates.

This report was read by Secretary Morrison as follows:

Report on Permanent Delegates.

Last year we had reported 180 Permanent Delegates. I can find only 175 recorded. The names of five elected Permanent Delegates are missing.

We have lost two delegates by death: John J. Broderick of Hudson, and George L. Romaine of Hunterdon, and one by resignation, David E. English of Essex.

The following have been requested to send excuses to the Judicial Council for absences: W. Edgar Darnall, Edwin H. Harvey, John E. Pratt, George R. Kent, Chas. F. Underwood, H. J. F. Wallhauser, Walter S. Washington, Mortimer Lampson, William J. Sweeney, Frederick W. Flagge, John G. Wilson.

It is necessary now to make some reference to the membership in this House of Delegates. In 1922, with a total membership in the Society of 1,867, there should have been elected enough delegates to bring our total representation up to 186. After the election there were only 178. This year the number has fallen to 167, or at least this number is all I can find recorded. In some way the names of several of these elected delegates have been omitted.

It would seem apparent that one of the chief methods of maintaining the interest in these meetings would be to have a full representation from the Component Societies. When the larger counties have ten or twelve of their Permanent Delegates absent, they still have a representation large enough to take an active

part in our deliberations and to maintain their voting strength. But when two or three of the delegates are absent from the smaller counties, their representation here is negligible. Last year the eleven counties of Atlantic, Bergen, Cumberland, Gloucester, Hunterdon, Middlesex, Mercer, Monmouth, Somerset, Salem and Warren had only 41 Permanent Delegates. They should have had 62, a loss of 21 delegates.

Because the names of some of the delegates are missing because of the complaints of many of the delegates that they were not seated, that some were marked absent when they were registered, because of the injustice done to the smaller counties, I shall move, under the Election of Permanent Delegates, that all the counties be given their full representation on this year's membership. This would bring our representation in the House of Delegates up to 203, apart from the Trustees and Fellows. I have had all the counties make these nominations except Sussex, where another meeting is not held until October. Of course, this can only be done by unanimous consent. If some delegate thinks more of adhering to the letter of the law as laid down in the Constitution than he does to correcting these errors, the motion cannot be entertained. In that event I shall offer only the nominations made to fill vacancies by death, lapses and resignations.

On motion the report was accepted and its recommendations adopted.

Secretary Morrison read a letter from the Secretary of the Medical Society of Pennsylvania, introducing Dr. Shoemaker as a delegate from that society.

President Eagleton: We will now hear from Mr. A. T. Nichols, as the representative of the Mayor of Atlantic City.

Mr. Armond T. Nichols: I just wish to say that His Honor, the Mayor, extends to you a real hearty welcome. It is only through the coming of such organizations as yours to our city that it has been possible for it to become what it is today and to have these large hotels. I take pleasure in handing you the key to our city. Please make yourselves at home here and if there is anything that the Mayor can do for you, he will be glad if you will call on him. I hope that you will have a very successful convention and that you will return here next year.

Secretary Morrison offered the following resolution from the chairman of the Gorgas Memorial Institute:

Whereas, The life and achievements of the late William Crawford Gorgas have been to our members an inspiration to service for humanity, and

Whereas, The Gorgas Memorial Institute contemplates the establishment in his memory of a living, working memorial in the form of:

(a) A Research Institute at Panama for the study, prevention, and cure of tropical disease, and

(b) the development of a national educational campaign under the supervision of the scientific medical profession for the purpose of improving and protecting the health of people everywhere.

Therefore, Be It Resolved, In consideration of these facts, that the New Jersey State Medical Society, assembled at its annual convention at Atlantic City, June 5th-7th, 1924, hereby heartily endorses the plan to memorialize William Crawford Gorgas in the manner contemplated by the Gorgas Memorial Institute, not only because it will constitute a worthy recognition of the character and achievements of our late distinguished colleague, but will be in effect a memorial to the efficiency and importance of medical science in world progress.

Upon motion the resolution was adopted.

Secretary Morrison presented correspondence with reference to the history of South Jersey, as follows:

A letter was recently received from the Lewis Historical Publishing Co., New York, requesting some brief information regarding the Medical Society of New Jersey, for insertion in their forthcoming History of South New Jersey. I wrote them as follows:

Gentlemen:

I take pleasure in forwarding you what information is at hand concerning the early history of South New Jersey from a medical viewpoint. The Medical Society of New Jersey was organized at New Brunswick, July 23rd, 1776. This Society is the oldest Medical Society in the United States. Its first President was the Reverend Dr. McKean, pastor of St. Peter's Episcopal Church in Perth Amboy. The charter members were: The Rev. Dr. McKean, Bernard Budd, John Griffin, John Cochran, James Gilliland, Thomas Wiggins, Christopher Manlove, Moses Bloomfield, William Burnet, William Adams, Lawrence V. Derveer, Isaac Harris, Jos. Sackett, Jr., Jonathan Dayton.

The war of the Revolution interrupted the activities of this new Society, and its charter was not obtained until 1790.

Dr. Robert McKean, its first President, died at Perth Amboy at the early age of 35. His body is interred in the churchyard of St. Peter's Episcopal Church at Perth Amboy.

On the occasion of the 225th anniversary of the founding of this parish, held at the old church at Perth Amboy, the Trustees of the Medical Society of New Jersey presented the parish with a marble tablet in memory of Dr. McKean, a cut of which and the addresses accompanying the presentation are enclosed.

You may weave as much of this as seems appropriate into your forthcoming History of South New Jersey.

Yours truly,

J. B. Morrison, Sec.

President Eagleton: I have received a letter from Dr. Woodward, of the American Medical Association, on lye legislation which I will ask the Secretary to read.

Secretary Morrison read the letter from Dr. Woodward and said: Such legislation for New Jersey was passed at the last session of the Legislature.

The resolution of the American Medical Association was then read as follows:

Safeguarding the Household Use of Lye and Other Caustic Substances.

Legislation is pending in Congress (S. 3112; N. R. 8917) to require that every package of concentrated lye and of certain other caustic substances, intended for household use and entering foreign or interstate commerce, be labeled "Poison." It has the approval of the Committee on Lye Legislation of the Section on Laryngology of the American Medical Association and is in harmony with the resolution adopted by the House of Delegates of the Association at the San Francisco session, in June, 1923, as follows:

Resolution of the House of Delegates of the American Medical Association relative to the sale of Concentrated Lye and Other Caustic Substances, adopted at the San Francisco Session, June, 1923.

"Whereas, The domestic use of concentrated lye and other caustic alkalies and of corrosive acids, in ignorance of their dangerous properties and of treatment in case of accident, is a not infrequent cause of death and of prolonged, distressing and incurable disability, particularly among children; and

"Whereas, In the judgment of this House, the adoption of suitable methods of packing, labeling and distributing such substances would materially diminish the danger; and

"Whereas, Efforts to bring about the adoption of such methods by the voluntary action of manufacturers and distributors has given no prospect of success, be it

"Resolved, That it is the sense of the House of Delegates of the American Medical Association, in convention assembled, that in the interest of public health and safety the packing, labeling and distribution of concentrated lye and of other caustic alkalis and of corrosive acids should be regulated by law; and be it further

"Resolved, That the Board of Trustees be instructed to take such action as may be necessary to procure the enactment of such Federal and State laws as may be necessary to effect such regulation."

The early enactment of the bills named above will tend to prevent deaths and disfiguring and disabling accidents, from lye and the other substances named. It will moreover establish a federal standard for such legislation and thus promote uniformity in such state legislation as may be enacted in this field. The prompt enactment of such legislation is therefore desirable.

The resolution was, on motion, adopted by this society.

The names of nominees for Permanent Delegates from the component societies were read as follows:

Atlantic County: Samuel Barbash, David Berner, Theodore Senseman. Burlington: D. F. Remer. Cumberland: Charles M. Gray, W. Leslie Cornwell. Essex: Wm. O'G. Quinby, to fill vacancy by death of Wm. S. Disbrow; Robert H. Rogers, to fill vacancy by death of Carl E. Sutphen; William Gauch, to fill vacancy by

death of T. Y. Sutphen; A. J. Mitchell, to fill vacancy by resignation of Geo. A. Van Wageningen; Alfred Stahl, to fill vacancy by resignation of David E. English; Frank Devlin, elected on quota. Gloucester: S. F. Ashcraft, William Brewer. Hudson: H. J. Perlberg, to fill vacancy by death of John J. Broderick; H. T. von Deesten, to fill vacancy by death of John J. Mooney; Joseph Koppel, Leo A. Koppel, G. W. King, Reeve L. Ballinger. Hunterdon: S. B. English. Monmouth: W. K. Campbell. H. B. Slocum, C. M. Trippe, Geo. Van Voris Warner, H. W. Ingling. Ocean: V. M. Disbrow. Passaic: John N. Ryan, Jacob Roemer, Henry Cogan. Salem: David W. Green. Somerset: Runkle F. Hegeman, Lancelot Ely. Union: Horace R. Livengood, elected to fill vacancy by death of E. B. Grier; Alvin R. Eaton, William J. Lamson. Warren: Chas. B. Smith.

Dr. Quigley, former president of Hudson County, said that Dr. Joseph Koppel was nominated two or three years ago as Permanent Delegate. Dr. Pollak called attention to the fact that it was Dr. Leo Koppel's name that appeared in this year's nominating list and not the name of Dr. Joseph Koppel, who was nominated two or three years ago. Secretary Morrison took exception to the election of Dr. Joseph Koppel as there was no record of it in the Transactions. Dr. Johnson asked if the members from Hudson County would allow the selection of both Dr. Leo and Dr. Joseph Koppel. Dr. Quigley called the attention of the meeting to the fact that Dr. John Mooney had died and that that left a vacancy. It was therefore voted upon motion that Dr. Joseph Koppel be elected the Permanent Delegate from Hudson County in place of Dr. John Mooney, deceased.

Upon motion regularly made and seconded, it was voted to elect all the Permanent Delegates on the list as read by the Secretary. Secretary Morrison cast the ballot for the names as read.

President Eagleton: We will now have the report of the Committee on Arrangements and Program, Dr. M. W. Reddan.

Dr. M. W. Reddan: I will let the work speak for us rather than words. I believe that we will have a very much larger and more enthusiastic meeting this year than ever before. We do not generally have as large a representation as this at the first session of the convention. I wish to urge you to visit the exhibits downstairs and to get acquainted with the men in charge of them. They are giving away things. I think you will find these exhibits very interesting. The Local Committee has tried to arrange a very nice entertainment for the ladies. We hope to make \$3,000 this year

and expect to spend most of it on your entertainment.

Upon motion of Dr. D. F. Weeks, it was voted that the society express their appreciation of the very able way in which the Committee on Arrangements and Program had planned for the entertainment of the delegates to the meeting.

President Eagleton: I wish to say that up to the time of the formation of the present Committee, about \$4,000 was paid out of the treasury for the Annual Meeting. Last year the committee turned over to our Society's treasury over \$1,300 surplus.

We will now hear the report of the Committee on Scientific Work, Dr. Franklin J. Keller.

Dr. Franklin J. Keller: For the report of the Scientific Committee's work I think it best to refer you to the program which contains the program of scientific papers we have arranged for you and which we turned over to the Committee on Arrangements and Program.

Dr. W. B. Johnson moved that the Committee be thanked for their work; the motion was carried.

The report of the Committee on Excuses of Permanent Delegates was read by Secretary Morrison. Upon motion of Dr. E. S. Sherman, the recommendations contained in the report were adopted.

Secretary Morrison: presented some bills from the Judicial Council. Upon motion they were referred to the Board of Trustees with the recommendation of the House of Delegates that they be paid.

The report of the Committee on Publication was presented by Dr. Charles D. Bennett showing amount of receipts and expenditures, as follows:

Statement of Charles D. Bennett, Chairman of the Committee on Publication.

For the year ending December 31st, 1923.

Accounts	Receipts	Expenditures
Official List	\$ 2.00	
Printing and Mailing		\$4,150.45
Reprint Account		62.05
Journal (sale of copies)....	12.91	
Editorial Salary & Expense		1,806.30
Chairman Salary & Expense		629.69
Advertising	5,035.99	
Cuts and Plates		4.50
Extra Subscription Acct. ..	29.70	
Subscription Account	2,090.00	
Commissions		500.71
Discount Account		111.97
Loss and Gain Account....	156.21	
Bills Receivable (1923)....		542.53
Bills Receivable (1924)....	825.82	
Net Profit		344.43
	<u>\$8,152.63</u>	<u>\$8,152.63</u>

Comparative Statement.

	1922	1923
Advertising receipts	\$4,637.80	\$5,035.99
Subscription (regular)	2,040.00	2,090.00
Subscription (extra)	41.90	29.70
Sale of Journal	10.05	12.91
Dividend Received	133.75	156.21
Printing and Mailing	3,890.07	4,150.45
Cuts and Plates	12.85	4.50
Editorial Salary & Expense	1,929.80	1,806.30
Chairman Salary & Expense	678.05	629.69
Reprints	48.55	62.05
Commissions	419.90	500.71
Discounts	95.38	111.97
Net Profit	300.43	344.43
Amount of advertising secured by Co-operative Medical Adv. Bur.	\$2,594.74	
Amount of discount and commission allowed Cooperative Med. Adv. Bur.		600.81
Amount of advertising secured by other sources		2,441.25
Amount of discount and commission allowed other sources		11.87
Total amount of advertising		5,035.99
Total amount of discount and commission		612.68
NET PROCEEDS FROM ADVERTISING		4,423.31
	1922	1923
Received from treasurer....	\$6,540.00	\$6,255.00
Paid to treasurer	4,067.49	4,413.05
	<u>\$2,472.95</u>	<u>\$1,841.95</u>

Amount per member approximately: In 1922, \$1.21; in 1923, 88c.

In the discussion following the presentation of this report, Dr. Reddan raised the question as to the \$600 item of commissions for the associated advertising. Dr. Bennett explained that this Bureau for Co-operative Medical Advertising is a department of the American Medical Association with headquarters at 535 North Dearborn Street, Chicago. He explained that is is a special department or bureau having charge of all official medical journals in the United States. It secures advertising for them and charges a commission and gives a discount of five per cent. for prompt payment of accounts. He further explained that some of this was returned to the Society, as appears in the item of \$156 in the loss and gain account, and that their system is something like that of the Mutual Life Insurance Companies, which distribute dividends from unused assessments. This association dictates what advertising shall be used, and no advertising can be used until it has been submitted to and approved by this agency of the American Medical Association. President Eagleton said it was important that the Society realize the tremendous amount of work being done day after day, and month after month, the whole year round by this Committee. He said it was only since his

position in office brought him into closer touch with this work that he himself realized this, and he wanted to give due credit to the men who worked so unceasingly and effectively in this connection. He spoke of the Journal costing each member this year but eighty-eight cents, including the entire cost of conducting the magazine, and said he thought each member should appreciate what was being done by this group of men and that the thanks of the Society should be extended to them. It was moved, seconded, and carried that a vote of thanks be tendered to the Publication Committee.

President Eagleton: We will now hear the report of the Secretary.

Secretary Morrison presented his prepared report as follows:

Report of the Recording Secretary.

President and Members of the
Medical Society of New Jersey:

We are assembled here today to open the 158th convention of our venerable society. Although we have a history of great accomplishments, a history rich in reminiscences, it is not my intention today to dwell on any of these. I am simply going to present to you a business report of your Record Secretary's office.

Our total membership Feb. 1st, 1924, was	2,079
New members elected since that date	45
Reinstated members since that date	20
	2,144
Deaths since Feb. 1st, 1924.....	4
Resignations and transfers.....	3
	7
Total membership to date.....	2,137
Total membership June 23, 1923	1,967
Net gain for the year.....	170
Total number of deaths for the year..	41
Total number of delinquents reduced to	24

I am pleased to report that all the Component Societies except two have shown gains in membership during the year. Several of them have every acceptable physician in the counties on their lists. All except five of the Component Societies showed 100 per cent. of their membership paid up at the time the Official List was published. I wish to take this opportunity to extend to the officers of the County Societies my thanks and sincere appreciation for the careful and painstaking assistance most of them rendered to me in the compilation of this list.

We have elected during the year to date 150 new members, and our total gain is 170. This remarkable increase in membership was partly due to letters which our President, Dr. Eagleton, sent out to every non-affiliated physician in the State, inviting him to join our Society and assist us in the great work we were endeavoring to accomplish. But the chief credit is due to the energies of special new membership committees acting in every Component

Society this year. In each society I visited this matter was taken up and active, energetic committees appointed. The results speak well for their efforts.

Acting in conjunction with Dr. Pinneo, the Secretary of Essex County, we have secured a field worker from the American Medical Association to canvass the entire State for new members. This man is working under the explicit instructions that he must not start a canvass in any county without first going over the list of available physicians with the Secretary of that county. Only such physicians will be approached as are known beforehand to be acceptable. I have written to every county requesting the Secretary to furnish me with such lists and most of them have responded. Besides these the canvasser has cards from the A. M. A. for every county in which he works.

This canvass is being undertaken without any expense to the physicians, the counties or to the State Society. The man is at present working in Essex County and as a result of his work that county elected 43 new members at the May meeting. By the time the entire State has been covered we expect an increase of at last 200 new members. I earnestly hope that this representative will be given the sincere co-operation and active assistance of every county officer. Local prejudices and animosities should be overcome; doubts which do not amount to convictions should be put aside; the broad spirit of brotherhood and fellowship should be extended to these men, and we should realize, that when necessary, we can exert far more persuasion and pressure on men once they are members of the county societies than we can when they remain outside. They need the benefits of our County and State Societies, and we need their support and co-operation. This is the time to put forth every possible effort to unify the entire profession in the State.

The hand of death has been laid heavily upon our Society this year. 41 of our members have passed to the "Great Beyond." Their names have been so marked in the Official List. Obituary notices have appeared in the Journal. Faces long familiar to us here are absent; voices that have taken an active part in our deliberations are stilled, and we feel our sense of loss keenly indeed. Dr. Enoch Hollingshead, one of our Fellows, who was President of this Society in 1913, and Dr. George Evans Reading, Secretary and Treasurer of the Component Society of Gloucester for many years, are among those whose activities will be most missed in this House of Delegates. They were truly "Doctors of the old school," men of noble characters and high moral standing, their lives have been an inspiration to this body, and will continue to be such for years to come.

In the interval between our meetings it has been my privilege to visit the Component Societies of Atlantic, Bergen, Burlington, Camden, Essex, Hudson and Union. It should be a settled policy of our Trustees to see to it that the Recording Secretary or some definitely selected officer of this Society visit the Component Societies every year, and that these officers should be pledged to make these visitations. Nothing keeps up interest like the personal touch. The members in these societies are berated when they do not attend their county

meetings or when they do not pay their dues, but we should realize that they are the very bone and sinew of this parent association, and that they are justly entitled to a personal presentation and discussion of the great subjects confronting us. It will be far easier for them to keep up the interest in their local associations if they felt we were lending them all the assistance, stimulation and encouragement within our power. Our Councillors could do much more in this line than is being accomplished. The county societies appreciate very keenly the visits of our Presidents during the past few years, and are sensitive to the fact that these visitations are germane to the very life of this parent association.

In justice to myself and this Society, I am compelled to have it recorded in the Official Transactions that when I took over the duties of your Recording Secretary there were no records of the Official Transactions of the Medical Society of New Jersey on file in this office from the year 1859 to the year 1918. If the history of this Society is continued in print in the future, these records will have to be searched for in the libraries of the State. I wish also to state that there were no membership records whatsoever except the Official List of 1923.

We have built up a card index system both for the counties and for the Alphabetical Lists, with records of all deaths reported, all new members, transfers and resignations. In constructing these card systems and compiling the Official List, ten thousand names were typewritten in my office. The labor will not be so great in the future because we now have an accurate basis to work from, but I want you to realize that the work of this office, properly conducted, is enormous. For instance, we have added 150 names to the lists since they were published. When these are put on the county card systems, on the alphabetical card systems, reported to the A. M. A., which is compulsory every month, sent to the State Journal for publication and to the Publication Committee so that the new members may receive their Journals without delay, when they are again added to the two lists this winter for the next Official Lists, it means that this 150 names have been handled seven times, or that 1,000 names have been so handled. Before the year is out, with our increase in membership, there will be three thousand more to be so printed. I mention this only to show you that with the increase in membership the work in this office increases in arithmetical progression.

Two thousand seven hundred pieces of mail have gone through my office this year and have received my personal attention. No letter remains unanswered 24 hours if the information asked for is at hand. I am calling your attention to these facts to show you that with the ever-increasing correspondence and with the great increase in membership during the last few years, no man who is not retired from active practice can perform the work of this office and keep the records in such form as to be of any value to this Society without assistance. I am compelled to employ a half-time assistant to take care of the manual and clerical work which is assuming such great volume.

Respectfully submitted,

J. B. Morrison, Secretary.

At the conclusion of which he made the following remarks: I would like also, if I were able to do so, to extend the activities of this office. It seems to me that you should have on record in your Secretary's office a report on every case of a violation of the Medical Practice Act that is referred to the Board of State Medical Examiners. You should have on file a copy of the evidence sent in on every case. As it is, we have no record except those that come from that office. If we had these records on file, when they had accumulated to one hundred, one hundred and fifty or two hundred, we would have some data upon which to work in connection with cases that had not been prosecuted; we would know the disposition of every case; we would know whether it had been handled or whether it had not. And when these cases accumulate, as I have suggested, we would know what course of action we might pursue in order to find out why. If we go to the Board of Medical Examiners then and ask why these cases have not been handled, we would get an answer. If that isn't satisfactory, we can go to the Attorney-General. If that isn't satisfactory, we can go to the Governor of the State. If that is still not satisfactory, we can go to the largest, most effective source of influence in the country—the public press. There is no reason in the world why this State Society should have to prosecute these cases. They are violations of the law, the same as any other violation of the law, and it is either a county or a State function to see that they are taken care of.

If this record were in file in my office, as I say, we would have something upon which to work and in all probability we would get some results.

There are other activities that I would like to take up but my activities are limited, I must say, by the amount of appropriations set aside for the conduct of this office.

Dr. H. B. Costill: Individually, I cannot let such a report as this go by without saying something for it. It has been an unusual report. Many of the recommendations that our Secretary has given us should be adopted. I want to make two motions: First, that we accept this report with sincere thanks of the Society for the voluminous work that has been accomplished; the second motion is that on account of the activities constantly increasing, we recommend to the Board of Trustees the providing of a permanent, full-time assistant for the Secretary of the Society.

President Eagleton: It has been moved and seconded that this report be received, that the House of Delegates concur in the recommendations contained therein, and also that we recommend to the Board of Trustees the furnishing to the Secretary of a full-time assistant to transact the secretarial work under his direction. Is there any discussion.

Dr. C. A. Rosewater: Mr. Chairman, I think at this point it would be well to bring up a matter of great importance, which somewhat goes further than the suggestion made by Dr. Costill. I believe the day is coming, if it has not yet arrived, when the Society will see the wisdom of not having an honorary Secretary with a paid assistant but of employing a superior man to devote his entire time to the business of the Society. I believe the work that Dr. Eagleton has done will not be done by any other man. No man will give the time and the energy to this work that Dr. Eagleton has given to it. The Secretary has just shown you what he has done. We must have, if we are going to get anywhere, if we are going to be big enough to face the economic problems which are coming to us day by day, somebody on the job every day in the year to look out for our business interests and the welfare of the Medical Society. So I would offer as an amendment to Dr. Costill's motion that the Trustees be authorized, if they see fit, to employ a full-time man to take care of the business interests of the Society. They would then have the power to decide how much this man should get if he were employed, how the money should be raised—whether we should tax each man five dollars a year, or raise the money in some other way. So I would offer as an amendment to Dr. Costill's motion that the Trustees be empowered to employ a man to devote his entire time to the business of the Society. The amendment was seconded.

Dr. C. R. P. Fisher: It seems to me the last speaker has just simply dolled up the meat of Dr. Costill's motion. It is just the same thing, voiced in a little different language.

Dr. W. B. Johnson: It seems to me that what the Secretary needs is a full-time associate in his department. As to the other matter, the employment of an individual to devote his entire time to this work, I think our Secretary does need it, in fact, I know he needs it, and I believe further than that we need just exactly what Dr. Rosewater suggests; we need a man to

look after the interests of this Society who will associate himself with the other departments of the work and with the Welfare Committee. I think that Dr. Costill's motion is correct and that Dr. Rosewater should reserve his amendment.

Dr. G. V. E. Warner: It looks to me like we are trying to make hash out of the beautiful six-course dinner. In the first place, we have heard an able report on a very active and full year's work. In the next place, the man who has done this work only asks us to give him some one to assist him for the coming year, to lessen his labors somewhat. Why mix up a business proposition with something for which a man has received glory and which will rebound in our minutes to his honor for the work he has done? I say vote down the amendment and call for the original motion.

Dr. Eagleton: We will now vote on the amendment which has been offered, and seconded.

Dr. N. L. Wilson: I appreciate what Dr. Rosewater says, for this reason: Dr. Eagleton will cease to be the Chairman of the Welfare Committee. We need somebody to take his place. Who shall it be? It must be somebody who can devote the same amount of time to it that Dr. Eagleton did. While I am going to vote against Dr. Rosewater's amendment because I think it should come afterwards, at the same time you can see what he is aiming at. We do need a business man to carry on the work of this Association if we want to run it efficiently. If we are going to get anybody to take Dr. Eagleton's place while he is traveling around the world, it must be somebody who can devote his entire time to it. I think that is what Dr. Rosewater means.

Dr. C. A. Rosewater: I withdraw my amendment, then, in order to clear the atmosphere.

President Eagleton: We will now vote on the original motion, that the report of Dr. Morrison be accepted and that a recommendation be transmitted from this House of Delegates to the Board of Trustees that they be empowered to employ a full-time secretary to act under his direction. I want to express my personal appreciation and thanks for the work Dr. Morrison has done this year. As he has said, no letter has come to the office of the President and been transmitted to the Secretary without the President having been informed of the statute of that member within twenty-four hours, and a large number have come in.

When he says that the same care was exercised in taking care of the members and all other business, you can appreciate the tremendous amount of time he has devoted to the work and the able way he has conducted it. All those in favor of the motion signify, by saying "aye," contrary-minded "no." It is unanimously carried.

Dr. Alex. MacAlister: I want to say as Secretary of the State Board of Medical Examiners, that the records of the State Board will be open to Dr. Morrison at any time he desires to consult them.

President Eagleton: The next report is that of the Board of Trustees by Dr. D. C. English:

Report of the Board of Trustees.

The Board of Trustees of the Medical Society of New Jersey met in the Academy of Medicine of Northern New Jersey, Newark, on September 21, 1923, at 3 o'clock P. M. Chairman Sproul presided. Present—Drs. Sproul, Eagleton, Costill, Morrison, Marsh, Dickinson, Hunter, Pollak, Wilson, Hollingshead, Schauffler and English.

Dr. Dickinson offered the following resolutions, which after discussion were adopted:

Whereas, We record with deep regret the resignation of Dr. William J. Chandler as Secretary of the Medical Society of New Jersey, whereby the intimate and pleasant relations which have existed between us for twenty-two years have been severed; therefore be it

Resolved, That we express our appreciation of this unselfish labor on behalf of the Society and our sincere regret that he has found it necessary to sever his connection with this Society. During all his many years of service, Dr. Chandler has labored faithfully and efficiently for the improvement of the Medical Society. Notwithstanding the demands upon his time by the requirements of his profession, he has given his services generously and performed the duties of the position to the satisfaction of all. His agreeable character and genial disposition have endeared him to all his fellow members, and he may always feel assured of our great personal regard for him.

Resolved, That these resolutions be spread in full on the minutes and a copy presented to him with our sincere wishes that success may always attend him, and that he may always enjoy the happiness and prosperity which he so justly deserves.

On motion the Secretary was instructed to write to Governor Silzer, thanking him for appointing Dr. A. F. McBride, Labor Commissioner and expressing our unanimous judgment that it was an eminently proper and wise appointment. The Secretary was requested to send a copy of this action to each County Medical Society for its approval.

Treasurer Marsh reported a balance on hand of about \$1,800. On motion the following was adopted:

Resolved, That Treasurer Marsh be and he is hereby authorized to invest such amount of the balance on hand as he shall deem best, in Government Securities, for the Society's interests.

On motion it was resolved that the Recording Secretary of the Society shall receive \$950 per year for salary and expenses; also that Secretary Morrison be paid for the amount paid by him in purchasing a filing cabinet.

The vacancies in our State Society's Delegates to the A. M. A., which the Society at the annual meeting authorized the Trustees to fill, was considered and Drs. D. C. English and H. B. Costill were elected regular delegates for the years 1924 and 1925. The following were elected alternate delegates to fill vacancies: Dr. G. H. Sexsmith for 1924 and Dr. James Hunter Jr. for 1925.

On motion it was ordered that the railroad expenses of the delegates to the A. M. A. be paid by the Society.

The date of the Society's next annual meeting was considered and June 5 to 7 inclusive was agreed upon unless a subsequent meeting of the Trustees should deem it best to change dates. The Board then adjourned.

The Trustees met again last evening in Had-don Hall, Atlantic City, at 8.15 o'clock. Dr. O. H. Sproul was re-elected Chairman of the Board and Dr. D. C. English, Secretary for the coming year, 23 members of the Board being present.

The minutes of September 21st, 1923, were read and approved. The Secretary reported that he had sent the resolutions adopted at the preceding meeting to Dr. Chandler and Governor Silzer and received from each a letter of thanks, with congratulations on our Society's past record and wishing the Society continued prosperity and success.

Treasurer Marsh reported receipts and expenditures for the year 1923, showing balances on hand December 31, 1923: Cash in Bank, \$2,645.70; bonds and treasury certificates, \$14,786.50; total, \$17,432.20. Also that the cash balance on hand June 4, 1924, was \$7,064.72. He also reported bills payable \$209.76, which were on motion ordered paid. Drs. Johnson, Schauffler and Wilson were, on motion, appointed a committee to audit the treasurer's accounts.

Dr. C. D. Bennett, Chairman of the Publication Committee, read his report which showed a net profit of \$344.43 for the year 1923. His report was referred to the House of Delegates. The thanks of the Board were voted to the committee for its excellent work.

Dr. D. C. English was re-elected Editor of the Journal for the coming year at the salary of \$2,000 and necessary expenses. Drs. Wells P. Eagleton reported that the Welfare Committee has expended \$4,898.40 during the year ending June 1, 1924, and gave an exceedingly interesting report of the work done the past year.

Dr. H. B. Costill presented to the Board of Trustees the original petition of the Medical Society of New Jersey: "To the Honorable, the Legislature of the State of New Jersey," for the extension of its charter, read January 19, 1815, and com'd to Messrs. Munn, Bayard and Ellis." (This is given in full in the July, 1924, Journal, page 234.) It was accepted with the hearty thanks of the Board to Dr. Costill, and on motion, it was ordered, with Dr. Costill's approval, that the document be loaned to the

N. J. Historical Society, as the property of the State Society.

A communication was received from Dr. W. D. Olmstead, Secretary of the Committee of Arrangements and Program for this annual meeting, in favor of selecting Atlantic City for next year's meeting. On motion, it was referred to the Nominating Committee to be appointed by the House of Delegates.

Dr. B. S. Pollak offered a resolution in favor of periodic health examinations. It was referred to the Business Committee.

Dr. Eagleton moved that the instructions given last year to our Society's delegates to the A. M. A. annual meeting be given again to our delegates this year, as follows:

Resolved, That the delegates of the Medical Society of New Jersey to the A. M. A. annual meeting be instructed to use their influence, and to vote to disassociate editorship and general management of the A. M. A., placing the editorship entirely separate from the general management of the Association, so that the Journal may represent solely the scientific side of the A. M. A. The editor to devote his entire time to the scientific and ethical aspect of the profession, not to its business; and that they use their influence and vote that an ad interim meeting of the House of Delegates be held at the headquarters of the Association. That it is impossible for the House of Delegates to do their duty to the Association by having a meeting but once a year.

This resolution was, on motion, unanimously adopted. The Board adjourned.

David C. English, Sec'y.

Dr. Alexander Marcy, Jr.: I move its adoption.

Dr. Philip Marvel, Sr.: Mr. President, in order that the Society may not be laboring under a misconception of our rights and privileges, may I speak so that part of the report that refers to the resolution that this Society is asked to forward to the American Medical Association? The regular routine of work in the House of Delegates is a little bit different from what it is in our State Society. A resolution provided as is provided here, sent by your delegate to the American Medical Association, presents itself more as a command or demand upon the House of Delegates. Placed in that position, it will never get anywhere. If you want to have an influence for your Society or any member of your Society in the advancement of the interests of the medical profession, through the American Medical Association, it should be put in the form of a resolution without reference whatsoever to what the American Medical Association shall do with it, and given to your delegate. That delegate at the proper time, before New Business in the House of Delegates of the American Medical Association, will have an opportunity to present that resolution on the floor; that

resolution will promptly be referred to the proper reference committee. The support of your delegate, or any assistance that he wants to bring to hand, can be taken to the reference committee and your resolution supported there.

If the reference committee feels that there is sufficient merit in that resolution to warrant its recommendation to the House of Delegates, they will recommend it, and the House of Delegates will either accept it or reject it. But you will never get a resolution or a motion of importance for the medical profession, changing the constructive law of the organization, in any other way and it is foolish and a waste of time to attempt it.

President Eagleton: You have heard Dr. Marvel's suggestion.

Dr. E. D. Newman: I move you that the report of the Board of Trustees be adopted, with the exception of these two resolutions, which should be referred to the Committee on Business, they to bring their report in to this House. If there is to be any discussion along the lines of Dr. Marvel's discussion it should take place before the Committee on Business. They will come here and tell us just exactly the status of the thing.

President Eagleton: The By-Laws say: "The Business Committee shall be composed of five members of the House of Delegates, appointed by the President. Any questions of business before the Society or the House of Delegates for consideration may be referred to the Business Committee for subsequent report or recommendation."

Dr. H. B. Costill: That is undoubtedly the right place for it.

President Eagleton: Is it the sense of your motion that it be referred to the Business Committee, Dr. Newman?

Dr. E. D. Newman: Only these resolutions, Dr. Pollak's and Dr. Eagleton's. My motion is that the report of the Board of Trustees be received and accepted and these resolutions be referred to our Committee on Business.

Secretary Morrison: May I add to that motion that these recommendations be reported to the Committee on Business, with instructions to report back at the meeting of the House of Delegates tomorrow? Things get buried there some times.

President Eagleton: It has been moved and seconded that the report of the Board of Trustees be adopted and that the two resolutions contained therein be referred to the Committee on Business. The at-

titude that Dr. Marvel has taken about the A. M. A., speaking as a member of your Society, is the very thing that has brought the A. M. A. into disrepute; the idea that no member really has a right to have any opinion whatever about the management of the organization until he has gone to somebody and obtained the privilege of ventilating that opinion. That is absolutely undemocratic and is rapidly being changed and I wish to say this, that the appointment of the most important committee that has operated in the last few years by the American Medical Association is due to the activities of the Welfare Committee of the State of New Jersey. Your Committee called attention to certain facts that they could not disguise and they appointed a committee to take care of these matters.

Dr. Marvel: May I explain the point is that that is the working method of the Association; that no business shall be sprung upon the floor, voted upon and passed without proper consideration; and in order to prevent that taking place, every motion and resolution of importance must go to a reference committee, that this reference committee may thrash it out, analyze it, and determine whether it is a worthy proposition to be voted upon by that body. If that reference committee, who is responsible for their recommendations, does not think it worthy it reports to the House of Delegates that it doesn't think it should be adopted. If it thinks it is worthy, it reports to the House of Delegates that it should be adopted. Then it is up to the House of Delegates to act upon it as they think individually and collectively. It seems to me that nothing could be fairer; nothing could be more generous; nothing could more truly represent the American medical profession as each State has a representative sitting in that House of Delegates whose duty it is to watch whatever legislation is being brought up.

Dr. N. L. Wilson: I think Dr. Marvel is right. I think their working methods are right. It should be referred to a committee, just as we refer things to committees, just as the Legislature of every State refers things to its committees before bringing it before the entire body. What I want to know and what I think many of the other gentlemen want to know is what were the threats in that resolution which would appear offensive? If they exist, I want to vote for the motion to refer it to a committee to trim it up in as nice shape as possible so that we won't do as our recent

Congress did on the immigration question, slap the Japanese in the face.

President Eagleton: The motion is that these resolutions be referred to the Business Committee to report not later than tomorrow and that the report of the Board of Trustees as presented by Dr. English be adopted. Is there any further discussion? If not, all those in favor signify by saying "aye," contrary-minded "no." It is so ordered.

Dr. Johnson requests (and with your permission I will grant his request) that the report of the Committee on the Revision of Constitution and By-Laws be now heard.

REPORT OF COMMITTEE ON REVISION OF CONSTITUTION AND BY-LAWS.

Dr. W. B. Johnson: Mr. President and gentlemen, I have to report that through an unfortunate trend of circumstances, the By-Laws which were adopted last year were not published in accordance with the facts as they existed and therefore the committee has prepared a correct copy of the By-Laws and they wish to suggest that this copy of the By-Laws be incorporated in the new Constitution which will be presented now for its first reading. The By-Laws are here corrected as they should be. The mistakes have been eliminated from the Constitution and By-Laws as published, as I said, in consequence of the unfortunate train of circumstances which existed at that time. Dr. Johnson then read the proposed changes in the Constitution and By-Laws. This, together with the corrections on the copy of the old Constitution, is the copy of the Constitution as read today and which must go to three readings before it passes.

(These amendments are substantially those given in the October, 1923, Journal as having been reported by the committee at this year's meeting. They will not be here given as the exact revision will be published later in our Journal).

Dr. H. B. Costill: I would move, Mr. Chairman, that that report be published in the Journal so that each member will have an opportunity to look it over before next year's session. It will have to lay over a year, anyway.

Secretary Morrison: I wish to suggest the following amendment to the By-Laws: In Chapter 1, of the By-Laws, strike out Section 2, and substitute therefor, "February 1st in each year is hereby set aside as the date for closing the official list. Five days before this date, the Treasurer of each component society shall report to the Re-

cording Secretary and to the Treasurer of the Medical Society of New Jersey a complete list of all the paid-up members with correct addresses. After this date no names shall be accepted for the official list."

Dr. H. B. Costill: How is it now?

Secretary Morrison: Now there is no time set by the By-Laws. The previous occupant of this office tried for three or four years to get the Society to appoint a committee to designate some time for the closing of the lists. It was never done.

Secretary Morrison read another correction suggested for the By-Laws.

Secretary Morrison: Strike out Section 9, Chapter 15, which is covered in this, that is, Section 9, Chapter 15 provides that the component society shall furnish one of these reports I am requesting.

Dr. James Hunter: I move that the report of the Committee on Revision of the Constitution and By-Laws be referred back to the committee with the amendments offered by Dr. Morrison; that they send their revision to the Journal for publication therein and that Secretary Morrison send a copy thereof to each component society at least two months before our next annual meeting.

President Eagleton: You have heard the motion. Is there any discussion?

Dr. G. Van Warner: It would seem to me that this committee ought to be able to prepare what we need. It has been a fact for the last two or three years that we haven't been able to find out exactly what the Constitution and By-Laws of the State Society are.

President Eagleton: All those in favor of the motion signify by saying "aye," contrary, "no."

The motion was carried.

(The report of the committee will be found on page 43, giving present and proposed sections.

President Eagleton: We will now have the report of the Committee on Honorary Membership, Dr. Walter B. Johnson, chairman.

COMMITTEE ON HONORARY MEMBERSHIP.

Dr. W. B. Johnson: I would like to report, Mr. Chairman and gentlemen, for the Committee on Honorary Membership that they have no candidate to offer. I would like at the same time suggest, and I think it would be a very desirable thing, if the names of the Honorary Members of this Society should be reported or noted on the annual program. I presume there isn't

a man here that could name the honorary members of this Society, and I think it would be a good idea if it were published on the annual program of the meeting.

President Eagleton: If there is no objection, that recommendation will be forwarded to the Program Committee next year. We will now have the report of the Treasurer, Dr. Elias J. Marsh.

Treasurer's Report for 1923.

RECEIPTS—1923

Balance, January 1.....	\$4,030.55
Dues—	
Atlantic	\$1,385.00
Bergen	776.00
Burlington	336.00
Camden	775.00
Cape May	128.00
Cumberland	368.00
Essex	4,244.00
Gloucester	174.00
Hudson	2,312.00
Hunterdon	349.00
Mercer	896.00
Middlesex	943.00
Monmouth	512.00
Morris	528.00
Ocean	120.00
Passaic	1,296.00
Salem	184.00
Somerset	288.00
Union	408.00
Warren	248.00
	<hr/>
	\$16,270.00
Interest on invested funds.....	155.00
Interest on bank deposits.....	311.83
Committee on Arrangements.....	2,919.06
Committee on Publication	4,413.05
From Dr. Cregar, account Medical Defense	500.00
	<hr/>
	\$28,599.49

PAYMENTS—1923

Committee on Arrangements	\$ 1,614.86
" " Credentials	225.10
" " Hosp. Standardization	66.50
" " Publication	6,630.00
" " Welfare	2,996.89
Trustees	9.80
Legal Expenses	1,752.85
Printing and Stationery	517.15
Expenses of President's Office.....	10.48
Expenses of Treasurer's Office	66.56
Salary and Expenses of Secretary..	1,794.71
Annuity, Dr. Chandler	250.00
Accrued interest on securities purchased	18.89
Transferred to capital account.....	1,000.00
Balance, December 31.....	2,645.70
	<hr/>
	\$28,599.49

CAPITAL ACCOUNT

Dr.	
Jan. 1—2m 1st L. L., 3 ½ % bonds.	\$ 2,000.00
Jan. 1—2m 4th L.L., 3 ¼ % bonds	2,000.00
Jan. 1—1m Chi. & Alton, 1st lien	
50 yr. g. b.....	786.50
Oct. 5—Cash	8,000.00
Dec. 17—Cash	2,000.00
	<hr/>
	\$14,786.50

Cr.

Dec. 31—2m 1st L.L., 3½% bonds.	\$ 2,000.00
" —2m 4th L.L., 4¼% bonds.	2,000.00
" —1m Chi. & Alton, 1st lien	
50 yr. g. b.....	786.50
" —8m Treas. Ctfs. T. M. 1924	8,000.00
" —2m Treas. Ctfs. T. D. 1924	2,000.00

\$14,786.50

Cash Balance 2,645.70

\$17,432.20

Respectfully submitted,

Elias J. Marsh, Treas.

Treasurer Marsh said: I want to say a word about the way in which the Society's business is done. I can't say that it is done in an absurd method because, while it may be absurd, there is no method about it. There is no system, nor co-ordination of the Society's financial business. In the first place, this report that I have just read is for the year 1923. That goes back some five or six months before our last meeting last June. The accounts that I have just shown to the Auditing Committee, the vouchers et cetera, are for the year 1923, as I say, some of them going back five or six months before our last meeting, and on the other hand, the accounts and the business for the past five months will not be shown till a year from this time. They are not audited or reported until a year from this time. That is not a sound business system. However, it may not be very important. But there is another feature, and that is that the reports of the different committee chairmen (except the Publication Committee, which has its year the same as the fiscal year and the calendar year) naturally are from the last meeting until this meeting. That is the year in which the committees do business. But there is no co-ordination between the financial reports of the different committee chairmen and the report of the treasurer. There is no way of comparing the two, checking one against the other. That is not sound business.

There is another point and that is the question of the money raised and expended by the Society. In order to have it done in a business-like way, there should be a budget in advance to know how much money the Society is to raise and spend during the year, and balanced against the report the next year. As it is now, that can't be practically done. Some two or three years ago, if I am not mistaken, my predecessor at the end of the year had to borrow several hundred dollars on his personal note to meet the more pressing bills of the Society

before the money for the next year came in. At the end of this past year I had a balance of I think \$12,000 or something like that on hand.

In order to arrange a budget, there must be some harmony between the fiscal year and the practical operating year of the Society, and in order to arrange a budget, the Budget Committee must have some idea of what the committee plans to spend. But if their chairmen are basing their estimates (supposing they were asked to give estimates) on a year from now to next June, and if, on the other hand, the budget takes effect from the first of January (after their year is half over) to the next December or January, six months after the expiration of their normal term, they do not tally. The committees are mostly continuous and it doesn't make so much difference as it might, but it does make some difference, and especially last year when we had on hand more money than we needed and the dues (assessments as they should be called) were cut down this year thirty-seven and a half per cent. If our taxes were reduced that much we would feel we were doing pretty well. But still there is possibly more money than there is needed this year but if we cut down again there is no way of telling what the Welfare Committee may need next year. Of course they can't tell themselves because it depends on the legislative condition and that varies from week to week partly. But there are other things too that could be controlled better. And the point that I want to make now is not details, but the fact that there is no system or co-ordination or method about it, and I suggest that the Committee on Finance and Budget, which seems the most appropriate one, should be requested to present next year some co-ordinated scheme for controlling the entire financial business of the Society, in a sensible, business-like method.

President Eagleton: You have heard the report of the Treasurer. What is your pleasure?

It was moved that the report be accepted with thanks and that the recommendations be adopted.

President Eagleton: It is moved and seconded that the report be accepted with thanks and the recommendations adopted. That is, that the Budget Committee which is now in existence should have its attention called to the fact of the great discrepancy that there is between the time at which the Treasurer makes his report, and the time at which the special committees who are

spending money make theirs. That is the chief item, isn't it?

Treasurer Marsh: Yes.

Dr. H. B. Cosill: Can a Budget Committee control the time or the co-ordination of the various committees? It seems to me that that ought to be provided for probably in our By-Laws; that those dates should come together, giving us a fixed financial year.

Secretary Morrison: Changing the date of the ending of our fiscal year?

Dr. Costill: Yes, changing the date of the fiscal year, and making it come out all together. Then the Budget Committee could possibly act, but as it is now the Budget Committee has no right to change the date of our fiscal year, and in revising the By-Laws it seems to me that that would be very well to provide for.

President Eagleton: It is moved and seconded that the Treasurer's report be accepted and the recommendations adopted by the House of Delegates and the whole matter be referred to the Budget Committee for its guidance.

President Eagleton: All those in favor of the motion to accept and adopt the report of the Treasurer and refer the whole matter to the Budget Committee signify by saying "aye," contrary, "no." It is so ordered.

Dr. Thomas Williams of Washington, who is attending a meeting of the Psychiatric Society, is with us this morning and we would be very glad to hear from him.

Dr. Thomas A. Williams: Mr. President and gentlemen, I wandered in here inadvertently, thinking this was a general session, but I saw several of my friends here and they asked me to stop, which I was very glad to do, because I had supposed that tinkering with constitutions was a matter rather confined to Washington life, but I see that there is quite a good deal of it here among the medical lawyers of this Society. What I came in for was to ask some of my friends in this Society to come over to the session of the American Psychiatric Society. I was very much surprised to find that even Dr. Marvel, who is a member of the Neurological Society, didn't know about our meeting. The sessions have been most attractive, and I think the President in particular would have been much edified by hearing what was said at the annual ovation last night, because I remember with great pleasure the most trenchant remarks he made in his address last year. The address last night was by

Dr. Barker of Baltimore, and concerned the duty of the psychiatrist in public health. It was an appeal not only to us psychiatrists, but to all physicians to enter a little more in public matters, to influence legislators and public men, and to advise them as to the very grave dangers besetting the public now on account of the enormous propagation and immigration of the unfit, a problem that I think we all thoroughly appreciate and a problem which is very difficult to deal with, especially as regards immigration now because, as you know perhaps, and as Dr. Dawes of New York said in a true "hell and Maria" fashion (like his namesake) in a most wonderful talk yesterday morning, the State of New York is spending a sum of money running into the millions of dollars per annum for the support of dependent aliens who should be deported. That is a tremendous expense to the State, to be borne by the taxpayer who is already greatly over-burdened, and it is a matter that is entirely preventible. What interferes with the carrying out of proper measures for prevention is obstructionism in the United States Congress, on the part of Government officials, especially the Secretary of Labor, who is not acting under the law to deport these individuals, for reasons which we do not know. Dr. Dawes appealed to the profession to interest themselves in this matter through their Congressmen so that the law as it stands will be carried out.

Another matter, taken up chiefly by Dr. Baker, was that we find some means of increasing the fertility of the more fit, encouraging their reproduction, because as we all know the classes who have been successful and who are therefore presumably more fit are not reproducing as they should and the people who are reproducing are the people who are filling the jails and asylums and who are becoming dependents. How that should be done, nobody knows, but it is a medical problem largely.

President Eagleton: We in New Jersey thought we knew.

Dr. Williams: We know in the case of individuals, but we don't know how to do it in a public fashion, from the public point of view. Our sessions are not over. Tomorrow morning there will be a very beautiful presentation of the whole matter of mental hygiene which every physician should be come acquainted with. This subject will be presented by Dr. Stanley Abbott of Boston, whose work in Philadelphia I think many of you know. We think that

the doctor's duty as a conservator of public health doesn't end when he prevents the spread of contagions and when he looks after quarantine, and when he performs the duties now devolving upon public health officials and county health officers; we think that he ought to do something to conserve what we call "mental health" by becoming a little better acquainted with the causes which lead to anti-social behaviour in young people (and it isn't a matter of too great difficulty for any physician to become informed about it) so that he will not only help the community but he will help his own patients. He will also do a great deal of indirect good in that way by doing for the people what is now being done for them by these quacks and charlatans who are posing in all kinds of guises as physicians, like osteopaths, chiropractors, Christian Scientists, and so on, and who only prosper because our patients—our public—do not understand the way in which these cures, so-called, operate. If we know enough about mental hygiene—because most of them operate because of their mental influence—we shall be able to spike the guns of these charlatans by a gradual process of education. We think, therefore, that the profession should support the mental hygiene movement more than they do at present.

Then there is also announced in the program a very interesting paper about industrial neurosis, and those of you who have to do with industrial cases in practice know how troublesome the neurotic individual becomes, but how, in reality, simple is the problem of restoring a man like that to useful life if you only know how. It is not a very difficult thing to learn how. I didn't mean to make a talk, but I can't help feeling that the profession at large holds itself a little too much apart from the work of the neurologist and the psychiatrist, perhaps because they are impressed by the difficulty of the subject (which isn't so difficult as it looks) and by the confusion of opinion which comes before them. That confusion is rapidly being replaced by a coherent formulation of the meaning of neurological diagnosis and psychological diagnosis and of the way in which patients of that kind can be dealt with, according to the common principles under which we all work, namely: those of clinical medicines and therapeutics. There is no essential difference between psychiatry and internal medicine, except that some of its operations have to do with chemical disturbances or

mechanical disturbances, like trauma, but with dynamic disturbances which we call psychological. It has been a great pleasure to have had this opportunity to talk to you.

President Eagleton: We are very glad to have heard what Dr. Williams had to say. Your President, because he happened to be the President of the Medical Society of New Jersey, was invited by the American Psychiatric Society to address them and he tried to lay before them what New Jersey had done just along these lines that Dr. Williams had spoken about, and he was gratified with the reception he received, and was shown the necessity of every physician studying these problems and actually trying to put them into effect.

Dr. W. B. Johnson of the Auditing Committee will now make his report:

Report of the Committee on Audit of the Treasurer's Accounts, Dec. 31st, 1922, to Dec. 31st, 1923

We have examined the books and vouchers of the Treasurer and the certificate of the contents of the Safe Deposit Box, and the report of the Treasurer and we report that all are in good order, and that the balances are correct in every detail.

Walter B. Johnson, Chairman; W. G. Schauffler; Norton L. Wilson.

President Eagleton: This report will be received and will take the usual course. We will now hear Dr. Philip Marvel's report as to the Delegates to the American Medical Association.

Dr. Marvel presented his report as follows:

Report of Delegate to the American Medical Association.

This is my first opportunity to make a report to the Society of the meeting of the American Medical Association held in San Francisco, June, 1923. The late Dr. Geo. Reading of Woodbury being our accredited delegate, was unable to attend the meeting and made the recommendation to the President, Dr. James Hunter, which resulted in my acting as his alternate. I attended both the business and the scientific sessions and am glad to be able to report the proceedings were harmonious and thoroughly business like in the House of Delegates—the legislative department of the Association. Many resolutions, bringing forward constructive suggestions, were read and referred to the reference committee. The amount of business transacted in the limited time appointed emphasized the wisdom of the legislative and scientific committees in scheduling the business program of the Association for the first two days of the meeting—particularly so, as all new business, matters of polity and constructive advances in the Association's chief interests are required to be presented within the limit of these two days. All unfinished business and the election of officers, etc., have a special day and time for their transactions.

he scientific program was of unusual merit—permitting of no unfavorable comment or criticism except among a few, who questioned the tendency to a too highly technical program. One advance made through the recommendation of the reference committee on "Section and Section Work" is of importance, particularly since the House of Delegates oppose, for the present, the admission of any new sections. Much interest and some feeling was exhibited by the Roentgen Ray men who requested the House of Delegates to rescind the resolution previously passed prohibiting new sections. A compromise was effected whereby the different sections were recommended to open their programs for contributions by the x-ray men and it was suggested that the program of each of the scientific sections should contain at least one or more papers on the subject of Roentgen Ray or Radium Therapy. The compromise effected was much more satisfying to the "Ray" men than an independent section would have been. It made it possible for them to be represented on 16 programs instead of one with one or more contributions, representing all divisions and specialties in medicine, with the opportunity of discussions from the clinical and practical point as well as from the technical determination of the evidence at hand. It has come to my attention that the manner in which your request by telegram to me, in San Francisco was presented, and its disposition, has been highly unsatisfactory to some of our members. If this be true, I am sure the feeling is altogether unwarranted and could not have occurred were the facts known and appreciated. In the first place the American Medical Association has its organic laws and schedule of procedure the same as other organized bodies, and possibly with reference to schedule of procedure, none are more iron-clad than the H. of D. of the American Medical Association.

Your telegram to me, signed by your President, Wells P. Eagleton, stipulating what your delegates should do, left no alternative whatever than what was done when the time allotted by the program for new business, had already passed, before the wire was received. Indeed had the reverse been the fact, viz: that new business instead of unfinished business was being received—the House of Delegates were in no state of mind to consider proposals or resolutions that in any way threatened the harmony of the session, or would be structurally disturbing to the present constitutional law of the Association, and particularly would the House of Delegates have quickly disposed of any attempt whatever to inject extraneous authority into the quiet and well thought out recommendations of their reference committees. The only way I could even get the matter before the House and have action at all, outside of having it declared out of order or immediately having it tabled without further consideration, was to request the unanimous consent of the House to have it read and referred to the Board of Trustees, to whom it rightly belonged, without discussion. This was done and when done it ended my responsibility to the demand contained in your telegram. For my self and my personal opinion, of the action of the Society, in the matter, was a different question. I was no longer bound by in-

structions, having discharged my obligation to both our Society and to the American Medical Association, I claim I was as free to declare my own opinion then and there, as I would have been here, and I did so by registering my personal objection to any action whatsoever, fundamentally directed to the basic laws of the American Medical Association at a time when it could only result in disturbance rather than unity.

I apologize for this lengthy detail, but feeling it is only proper that, since my action in the matter called forth criticism, in fairness to the Society and in justice to myself, the facts should be stated and, I hope, understood. My position was first to serve the Society which I represented, and second to uphold my own views, particularly so when, as a member of the House of Delegates, I owed it to myself to advocate what in my opinion was for the best interests of the Association whose constructive laws I was called upon to help make, and to sustain.

Addenda.—Telegram received by me June 23, 1923, from Atlantic City, N. J.:

Dr. P. Marvel,
Headquarters American Medical Ass'n,
San Francisco.

All delegates of the Medical Society of New Jersey to the American Medical Association are instructed by the Society: (1) to use their influence and vote to disassociate the present system of editorship and general manager, placing the editorship entirely separate from the general management so that the Journal shall represent solely the scientific and ethical sides of the American Medical Association; (2) that they use their influence and vote that an ad interim meeting of the House of Delegates be held at the headquarters of the Association.

Wells P. Eagleton,
Pres't Medical Society of New Jersey.

Telegram sent by me from Chicago, June 25, 1923:

Dr. Wells P. Eagleton,
President N. J. State Medical Society.

I should have text of resolution passed by the Society to file with House if necessary, also arguments in support of same. Please wire both. Will follow developments with your telegram in mind. Shall endeavor to act in best interest of both Association and Society.
Philip Marvel.

The answer to this was handed over to the clerk of the House of Delegates of the American Medical Association, which was the same as the preceding copy.

The report was accepted.

Dr. D. C. English then presented his report as Delegate to the New York State Medical Society, as follows:

Delegates to the N. Y. State Society.

Dr. D. C. English reported that he attended the annual meeting of the New York State Medical Society at Rochester in May. Was present at the opening meeting of the House of Delegates and received its welcome by a rising vote and an invitation to a seat on the platform and to take part in discussions. This I accepted, of course not as an honor to me personally

but to our Society in expressing their pleasure to have our Society represented there. The work of the House of Delegates was conducted with great care and success, the presence of their State Society Counsel, Lawyer Whiteside, whom we are pleased to have with us this year, aided much in solving difficult problems. The papers and discussions at the Scientific Sessions were exceedingly interesting and helpful. I was pleased to meet Dr. Schick, of Vienna, the eminent physician, author of the Schick Test, who read a valuable paper on diphtheria.

President Eagleton: You have heard the report of the Delegate to the New York State Society, what is your pleasure? It was on motion accepted.

President Eagleton: We will now have the report of the Committee on Standardization of the Degree of Disability in Industrial Eye Injuries, by Dr. Sherman of Newark.

STANDARDIZATION OF DISABILITY IN INDUSTRIAL EYE INJURIES.

Dr. Elbert Sherman: Mr. President, this report is the unanimous report of the Committee appointed at the suggestion of Dr. Marsh at the last meeting, that a committee be appointed to report on a method of estimating the percentage of permanent disability in eye injuries. As a report of this matter is necessarily of interest to only a very small group, the Committee felt it would be unfair to present the report orally and in full. Therefore, we have had it printed and have had copies distributed with the programs which I suppose you have all received.

For another reason, we wanted the report printed: because while it is of interest to only a small group, it is rather an important matter to that small group and we wanted every one who is interested to give the matter proper consideration before he was called upon to act on it. Therefore, with your permission, Mr. President, I will not read the report in full, but will only refer to two or three points which I wish to emphasize.

Dr. Sherman then presented the report of this committee, in abstract. For the report of this committee see the June Journal, page 206.

President Eagleton: You have heard this report, gentlemen, what is your pleasure?

Dr. N. Y. Wilson moved that the report be received and the recommendations adopted; that the standards therein approved be adopted generally throughout the State, and that the thanks of this Society be extended to this Committee, and par-

ticularly to Dr. Sherman, because this has entailed considerable labor.

Dr. J. N. Bassin: Dr. Sherman spoke about the muscles affecting the eyes as a consideration in percentage of disability, and that is a very important item. I am sorry that he didn't mention positively the prognosis of these cases for a short period of time, six or eight months, and I would recommend for future study of this subject that some definite data as to group prognosis in these cases be taken by Dr. Sherman or any of the other men who are doing this special work. This is an important item. I may incidentally state that in future work of the Society I should very much like to see similar standard studies for disability estimates of all the other members of the body subject to injury in industrial life, and not alone the eye.

The motion of Dr. Wilson was adopted.

Dr. Alexander MacAlister moved that Dean Meeker of the Post Graduate School of the University of Pennsylvania be elected a corresponding member of the Society during this session.

The motion was adopted.

President Eagleton: Next is the report of the Committee on Prize Essay, by Dr. Alexander Marcy, Jr.

Dr. Alexander Marcy, Jr.: Mr. President and gentlemen, in making the report for this Committee as chairman, I am more or less embarrassed. I appreciate very much the honor of being continued as chairman of a defunct committee, but I think the title ought to be changed to "chairman emeritus." (Laughter). Four years ago in making a report as chairman of this committee, I told the House of Delegates that for a number of years no prize essay had been presented to the Committee and that therefore I would recommend that the Committee be abolished. The matter was taken up by the House of Delegates and the Committee was abolished but every year I am put down on the program as chairman of this Committee on Prize Essay and asked to make a report. I am perfectly willing to come here and stand up and tell you this, but it seems to me that if you will just make me chairman emeritus of this defunct Committee you will save some time and some expense for printing, and all that sort of thing.

President Eagleton: The chair will appoint Dr. Marcy the chairman emeritus of this defunct committee. (Laughter.)

ADJOURNMENT.

THURSDAY AFTERNOON SESSION.

June 5, 1924.

The meeting convened at 2.45, President Wells P. Eagleton presiding.

President Eagleton: I will call for the report of the Hospital Standardization Committee, Dr. McCoy, chairman.

HOSPITAL STANDARDIZATION COMMITTEE.

Dr. J. C. McCoy: The activities of the Hospital Standardization Committee during the past year have been devoted almost exclusively to the nursing problems in the State. Those of you who have read the Journal will recall in a recent issue a full report of the activities of the Hospital Standardization Committee, to which Committee was turned over by the State Welfare Committee a consideration of the nursing problems of the State. After numerous meetings with the representatives of the State Medical Society, the representatives of the various nurses' organizations in the State, and representatives of the Board of Managers of the Standardized Hospitals of the State, numbering I think forty-eight, and considering the strenuous opposition evinced by the nursing profession in the State to the carrying out of the recommendation made last year by the Hospital Standardization Committee—namely: That the medical profession and the Boards of Managers and the nursing departments recognized that there was a shortage of nurses in the State, and that ways and means should be created for the establishment of a subsidiary type of nurse in the State—a committee was appointed by the Chairman of the Hospital Standardization Committee. That Committee consisted of nine members, three members of the Boards of Managers, three members of the Nurses' Association of the State, and three members of the State Medical Society. After numerous conferences extending over the year, it was the consensus of opinion that in order to meet the objections registered by the nursing profession, a plan should be adopted similar to that which was inaugurated in the Oranges some few years ago and which has been in successful operation during the last five years. The plan under which they operate in the Oranges is under the direction of Miss Gerhart and is known as the Visiting Nurse's Organization. This Committee recommended to the State Welfare Committee that such departments be established in various hospital centers throughout the State.

The operation of the plan in brief is as follows:

1—The object was to furnish home nursing at moderate cost; 2—That educational and age requirements were such as not to interfere with the higher standards demanded for hospital nurses working for an R. N.; 3—That the length of the course was to be one year; 4—That the training was received in the Nurses' Settlement, the home of the pupils, in the elements of housework and simple dietetics; 5—That classes and lectures were held regularly throughout the course; 6—That bedside instruction was given in the home by the graduate R. N. acting as supervisor, accompanying the pupil and taking the professional responsibility of the case; 7—Three months is spent in a hospital, where experience is gained in the general wards and in the children's and maternity wards; 8—During their seventh month pupils—"gray nurses" as they are called—are sent to private cases deemed suitable by their superintendent, but they continue to work under close supervision by daily or frequent visits from graduate supervisors. The price paid for this service is \$19 per week; 9—At the end of a year the pupil receives a certificate issued by the Visiting Nurses' Association.

The requisites for such a course are: 1—A well organized Visiting Nurses Association employing a sufficient number of registered nurses to act as responsible supervisors; 2—A superintendent of unusual executive ability and a personality which inspires enthusiasm in her pupils and makes them eager to meet the daily emergencies of the vocation with sympathy often entailing self sacrifice; 4—A hospital ready to welcome these pupils and to give them the opportunity of experience and observation in institutional methods. (Please pay particular attention to that clause); 4—A class of healthy, intelligent women eager to learn how to meet the home emergencies in the homes of the sick, as well as the technique demanded in the care of the sick, especially in the homes of moderate means, for which this service was designed.

This plan has been working successfully in Orange for four years. The demands for these nurses coming both from the medical profession and from individuals is far greater than can be supplied. The corps of supervise nurses number now fourteen; five times that number could be kept constantly busy.

The report was, on motion, accepted. For the full report see the May Journal, page 171.

President Eagleton: We will have the report now of the Judicial Council, Dr. Conaway.

Dr. Walt P. Conaway presented the report of the Judicial Council as follows:

Report of the Judicial Council.

I herewith submit my report as member of the Judicial Council from the Fifth District as well as reports from the First, Second, Third and Fourth Districts.

During the fiscal year of 1923, 1924, there were eight meetings of the Judicial Council. Six of these meetings were held at the Robert Treat Hotel, Newark, New Jersey, and two meetings at the office of our secretary, Dr. Edward S. Hawke in Trenton. During this time we considered fourteen cases where either suit had been started or notice or intention had been given. We were unanimous in our willingness to defend our members in each of these cases. As yet several have not come to trial, but since they are entirely in the hands of our attorney, Judge Wall, we feel no hesitancy in saying that each of our members will be defended by expert council.

There were several other cases which we considered informally but no direct appeal having been made to the council for defense, we, of course, took no official action.

Might I suggest, Mr. President, that we, the members of this council, would welcome some suggestions from members of this Society toward increasing our usefulness in these threatened damage suit cases. We feel that we are handicapped in that after devoting considerable time to a careful consideration of a member's conduct in any given case, we can promise only the small amount of \$200 or \$250 toward defraying his expenses in case a jury should award the plaintiff damages for many times that amount.

We suggest that the responsibility of the Judicial Council in a suit for malpractice should be limited to deciding whether or not the conduct of the defendant was worthy of defense and that we should promise nothing but the moral support of the Society. This would encourage each member to secure a sufficient amount of insurance to provide ample protection. We approve of the insurance company recommended by the Special Committee of this Society, but each member may of course, select any policy he desires. This, in our judgment, would increase the usefulness of your Judicial Council, but we invite constructive criticism.

Respectfully submitted,

Walt P. Conaway, Ch'm.

First Judicial District

Dr. Mefford Runyon of the First District reports progress.

Second Judicial District

As Councillor of the Second District, I have no business to report to the Judicial Council in addition to that which has already been presented and acted upon, a full record of the same being in the hands of Dr. Edward S. Hawke, our secretary. So far as I can learn, the several county societies in this District are in a good and healthy condition.

From the large number of suits threatened

and instituted against physicians in this State it occurs to me, as no doubt it also does to each member of the Council, that the medical defense offered by the State Medical Society is wholly inadequate for the purpose. I therefore hope that some action may be taken at this session of the Society that will urge each member to purchase a real insurance policy that will thoroughly protect them, both as to counsel fees and any monetary damages that may accrue. The cases which we have had to consider have all seemed unjust, unreasonable and without foundation, but nevertheless the instances in which cases have been instituted have grown more frequent, and until the physicians present a stronger line of defense this evil will not be checked.

Henry Spence,
Councillor Second District.

Third Judicial District

This year, 1923-1924, has been an uneventful one in the Third Judicial Council District. Meetings have been held regularly in all our county societies with instructive addresses and interesting discussions of cases. The attendance, so I have been informed, have been fairly fair. Fortunately we have been very free from malpractice suits, so far this year having only one threatened; this compares favorably with the remainder of the State, making me think we do not have as many hungry lawyers here as in Northern New Jersey.

Edward S. Hawke,
Third Judicial Council District.

Fourth Judicial District

Only one case was brought to the Judicial Council of the Fourth District during the year. After due consideration it was decided that this case should be defended. Later Council advised the defendant to make settlement for a moderate amount, acceptable to the plaintiff. We considered this a satisfactory result in this particular instance as the doctor had no insurance whatever and, in the attorney's opinion, it was an exceedingly difficult case to defend. The meeting of the county societies which I have been privileged to attend, have been interesting, well attended and the scientific work of high order.

It has been a real pleasure to meet the several members of the Society seeking medical defense and to discuss the various phases of this increasingly great menace to the practice of medicine in this State.

Thomas B. Lee,
Councillor Fourth District.

Fifth Judicial District

Meetings have been held regularly in each of the five counties included in the Fifth District. It was my pleasure to attend several of these meetings and in each instance I felt very well repaid for the time given. The attendance was particularly good, the papers of considerable literary value and the discussions in most cases especially interesting and instructive.

No damage suits were brought to our attention from Gloucester, Salem, Cumberland or Cape May Counties. Two suits were referred to us for investigation and for our moral support from Atlantic County. Both these suits, after investigation, we willingly offered to defend, but as yet neither case has come to trial.

We are pleased to say that fewer suits for damages have been instituted this year in this district, which condition we are glad to note holds true in the remainder of the State.

Walt P. Conaway,
Councillor Fifth District.

Upon motion, the report was accepted.

President Eagleton: The report of the Welfare Committee will be given in detail tomorrow night as a part of the President's address. I have looked at it in this way: That nothing I could say to you scientifically would be of the slightest interest to you as a body, while my experience and the experience of your Committee and the lessons that they have learned might be useful to the Society. But before that report, which will be in the nature of a public address, is made I wish to review what the committee has done and the recommendations that the committee are going to make for your consideration.

WELFARE COMMITTEE REPORT.

The Committee have operated about as follows: Beginning the first week in September, they held weekly meetings. After the first of October, not a week passed without our holding a meeting. We took up the health problems that were presented to us with the idea of studying each one separately so that when the Legislature came in session we would have some definite plan. We adopted the policy that we would protect the interests of the profession and of each individual member of the profession in this State, at all costs. We realized that too long had the profession, through inactivity—just passing it over to "George"—had no definite policy of protection. When you consider the fact that now the number of irregular practitioners that are licensed by the State is enormous, you can see that something must be done. We said, "we will protect the interests of the physicians individually and collectively. Secondly, we will try to improve the respect in which they are held by the community."

With regard to the second objective, we thought the easiest way to bring it about would be, first of all, by publicity, and second, by appearing in the legislative hall with solutions of problems that were regarded entirely as medical problems. Bills were prepared, after a careful and scientific study of medical problems, and they resulted in the well-known Marriage Certificate Bill and the Standardization Bill. Neither of these bills passed. They had a marked influence on the public mind. I

don't think physicians realize how much better their position is, especially with the women of the State for the men are not interested in it, because of these two bills. The women are saying, 'The doctors have come forward with a solution for this.' The Department of Institutions and Agencies are asking for millions upon millions, and they are very glad to give it to them, but there must be some other way.

Sterilization was the first effort that was made in this State, although some years ago it would have been declared unconstitutional. That thing had a very marked influence in increasing the respect in which the profession was held, because it was disinterested. The Marriage Certificate Bill has many defects, but is a result of a scientific study of the conditions and is the first effort that has ever been made by a body of physicians in the United States to do this. All other bills have come from the lay bodies. Both of these bills failed and we have decided, as I say, to go on with them next year.

As you know, as a result of the activities of your Committee, there was appointed by the Governor, after a conference of the Welfare Committee with him, a Medical Advisory Board. This was after a very courteous hearing on his part of our statement that the State was not being well-guided. He said, "If you will put that in writing, I will adopt it." We put the scheme in writing; he adopted it, and we sent a long list of physicians who we recommended as being eligible, out of whom he selected five.

We tried in our effort to protect the physician, to repeal the infamous bill that was put over on us last year, that tore down to a certain degree the requirements that we had established by the Limited Practice Act. This also failed through political chicanery in the House.

Out of a clear sky, there came the statement from the Governor in his annual message that the term "doctor" should be limited to those who had the right to use it. I want to thank Drs. Quigley and Pinneo especially. All the other members worked and worked well, but these men devoted a large amount of time to it. Opportunity was taken, because of the Governor's message, to prepare a bill. It was prepared by the Attorney General of the State. When it was turned over to us, we had just one evening to consider it, and it is the only bill that has ever come out of the Welfare Committee that has not gone

over line by line. It was read hurriedly and given to a Senator to introduce. We realized after it had been in his possession a few days that it was an infamous bill and we repudiated it, but immediately went to New York and had Mr. Whiteside prepare a bill and we also went to Mr. Stryker in Newark and had him prepare a bill for the same object, and out of these two bills was constructed by your Committee a bill (the body of it is entirely Mr. Whiteside's) that we introduced as Senate 159, which would limit the use of the term "doctor" to those who have had the right given to them by the State, whether they be osteopaths, veterinaries, or something else. According to that bill, an osteopath must put the word "Osteopath" after his name; a veterinary must put the words "Veterinary Surgeon" after his name; a dentist the word "Dentist," and so on.

This bill, of course, met with tremendous opposition. None of you here will realize the monetary interests involved in this, for there are over two thousand men who are using the term "doctor" (I didn't know this until last night) to deceive the public, and if such a measure can be put over (and it must be put over), it will be the biggest thing that has ever happened to the medical profession since the time we put over the Limited Practice Act. That bill passed the Senate and we had just one day to get it through the Assembly, when it was stolen. You can say it was lost or perhaps that a bird came down and put it under the rafters, but anyway, it disappeared. It disappeared for thirty-six hours. It had not reached the desk of the Speaker of the Senate. On the last day, the same man who was instrumental in defeating this bill was instrumental in passing the Chiropractic Amendment of this year. He was the one who was manipulating it for the interests.

Dr. Costill at last went to the Speaker and told him that they said the printer had it and that the printer absolutely denied it, and said it had been delivered to the proper department of the Senate. The President of the Senate went to the Committee where the bill had disappeared and demanded that the bill be presented to his desk, saying that too many bills had disappeared during that session. It was produced within five minutes. It then went over to the Assembly, being carried over by the clique of the Assembly. It was referred immediately to a committee headed by Assemblyman Stratton from Gloucester, who we knew would kill it if he could,

though he had pledged five separate physicians—and Dr. Kelly who is a good politician said "Send two of them together so they will hear it," and we sent two—that if it came to his Committee they would report it immediately. He locked the bill up. He gave all kinds of excuses as to why it shouldn't be reported and he kept it locked there for the remaining few hours of the session. The Rule of Fifteen could not be applied because we did not have time but we had in the Assembly the votes to pass that bill and next year that bill must be the body of the bill that the doctors will have to stand by, for if we are ever going to stop this unfair competition that every man is meeting, that will have to be the first step to combat it.

At the same time, the Board of Medical Examiners had introduced a bill, Senate 77. Senate 77 would compel all schools to obtain from the State Board of Medical Examiners a license to operate. That bill was examined by your Committee, and your Committee decided that it gave the Board of Medical Examiners entirely too much discretionary power, because it did not say what standard they would adopt before they were granted the license. So we insisted it should be written into that bill that before a license was granted, the school applying for the license should pay not only one hundred dollars but should furnish evidence that they had equipment and that they were of the standard of grade of a medical college, which is now required of medical men. That bill passed the Senate, came over to the Assembly, and it is due to Dr. Quigley's political acumen that it is now a law. By a strange coincidence, this bill, which was introduced from Gloucester, had to have speak for it the same Stratton who had defeated that other bill, although it did not go to his Committee. He also is from Gloucester and we realized that he would kill the bill if he could because he had killed every other measure, for reasons best known to himself.

So when the committee in whose hands it was reported the bill and it gradually crawled up the board and got near the top, the Executive Secretary went in search of Stratton: he found him and three times he promised he would come in and speak for the bill. When the bill was next to the top on the calendar and would have been called for at any moment, Dr. Quigley realizing that when the bill was called there would be no speaker for it, went to one of the men from Hudson, told him the story about

what they were doing to us and asked him if he would sponser the bill, which is against the ethics, if you might call it such, of the Assembly. He said of course he would, it was a good bill. Stratton and all the rest working against educational standards—and I want to say that Essex County is the worst offender of all the counties—wanted this bill to be defeated, that is, not to come to a vote. When 77 was called, a man jumped up and spoke for the bill, which I think is the only time that has ever occurred in this Assembly. Kindly prodded by Dr. Quigley he answered whatever questions there were, and the bill went over, having the necessary votes. It went to the Governor.

At the same time a chiropractic bill, which was in direct opposition to 159, giving them the right to do almost anything in the way of surgery on the feet, was before the clerk of the Assembly, the same Brodesser, who had seen that 159 was pigeon-holed, and with the connivance of Eaton, the speaker, the chiropractic bill had gone back and forth, like this, twice to the Assembly and twice to the Senate, and had passed. That night we stood this way: 77 had gone over—a great and definite advance because if it is enforced after the first of September these schools that have been granting degrees after three days for doctors of osteopathy, and I have documentary evidence to prove this) will no longer operate in New Jersey. One of these schools last Sunday had a whole page advertisement in the papers. They are still operating. After the first of September such schools will have to have a license from the Board of Medical Examiners.

We telegraphed the Governor that night asking him to sign 77 and asking him to veto the Chiropractic Bill, both of which he did. On the back of his veto of the Chiropractic Bill, he said, "There is not enough protection given to the public against incompetent men. They should not be allowed to do surgery." It is a fine piece of propaganda for intelligent people to use next year, and the Governor should be commended. I will read the whole statement tonight. In spite of that, when the Assembly reconvened under the leadership of the speaker that bill came up and was within three votes of being carried over the Governor's veto. It got twenty-eight votes when it needed but thirty-one to become a law over the Governor's veto.

Gentlemen, we realize that this is not a very glittering report. We spent practically

\$5,000 of your money. We realize this also, every one of us; that we have worked as hard as men ever did work, and while the Committees that follow us may act more wisely than we have, I am sure they will none of them serve with a greater spirit, or with a greater desire to be of service to every individual doctor who is qualified and competent to practice medicine in the State of New Jersey.

We have this recommendation to make—first of all, Mrs. Eagleton and I on the tenth of July are going around the world and we are going around slowly. We feel that this work must not stop, no matter who goes out; that this is a job of the Medical Society of New Jersey. You have put into this work now altogether about \$16,000 during the last three years. We feel that the work has only been begun. We feel that New Jersey is leading in the movement to interest the doctors in public affairs and public health.

I want to mention one other matter before I get at what we recommend: The Workmen's Compensation Act that we passed and the amendments to the Workman's Compensation Act are of tremendous advantage to the profession economically. It used to cost the insurance companies fifteen per cent. of the total amount of money they expended for medical services. Today it is costing them thirty-two per cent. of their total expenditures to pay the doctors. Of course, they're mad as a March hare. They say we are robbing them of one hundred and twelve per cent., but my answer is this: That before we passed that law they were receiving for \$100 what was worth \$212, and for which they are now paying what they should. (Applause). Every doctor who does industrial work is materially helped by that Law, no matter what anybody says.

Another thing is this: Your bills are inspected by doctors—not by an insurance carrier, not by a manufacturer, but by doctors. And they decided whether your bill is just and equitable. No other State has as good a system as that, so far as I can find out.

The Governor appointed Dr. McBride the head of the Department of Labor. This is a great compliment to Dr. McBride but we think it is also a great compliment to the doctors of the State that a doctor should be appointed to this position. There should be a doctor in that position. Three should be a doctor at the head of the Department of Institutions and Agencies. Only a phy-

sician is qualified to do such work, and if you had read the correspondence that I have had with General Hines, which we have conducted through Senators Edge and Edwards, you would see how benighted these men are in dealing with medical affairs. I told him the reason the Veterans' Bureau was in disrepute was because politicians were handling it, and it is a medical problem, and that if he put at the head of it some high type physician things would be straight. Of course, they don't like that kind of talk. We believe this work should go on. We believe you have spent too much money on it and your Committee have put too much energy into it to allow it to die.

There is now in the hands of Mr. White-side, who is the counsel of the New York Medical Society, all the medical laws and he has made a survey of them with a view to writing a law that would be applicable to New Jersey. And our instructions to him were these: "Put teeth in the Medical Practice Act of New Jersey." I am not going to burden you with reading this lengthy communication, but he has taken up each section and analyzed it (showing why it is weak and what a hodge-podge affair it has been). The medical profession have admitted concession after concession, so that if there originally was any value in the law, a great part of it has been lost. Mr. White-side will prepare one or two (if necessary, three) amendments to the Medical Practice Act in the places where it is weak, so the the physician who is qualified to practice by the State shall have the proper amount of protection against the irregular, untruthful, and unqualified practitioner. We believe that should be adopted by this Society.

Secondly, we believe that the Governor's message to the Assembly, in which he asked that there should be an appropriation of \$75,000 to survey the educational system, should be endorsed by this Society. for this reason: The State today, as you will hear from Dr. Haight, is spending millions of dollars for medical activities in the public schools. The doctors have never had any part in that. Therefore, we believe we should endorse the principles of the survey and also recommend to the Governor that on that Surveying Committee (if he gets his \$75,000 and the authority from the next Legislature to make the survey) there should be a high grade physician who knows something about educational matters and that under his direction there should be a survey of all the health and medical

activities which are now going on under the Board of Education. If we can succeed in doing that, the influence on the individual doctor will be great, because there is a tendency to take all this medical work out of the hands of the family physician and get it into little boards, where it is never well done; and the family physician, after all, are the men that should be looked after by you and by me in our official capacities for they are the body of the medical profession and the most reputable and best qualified men to do such work.

Last of all, we make this recommendation: That the Medical Society of New Jersey endorse the principle that the work of the Welfare Committee be continued and that a full-time paid executive be employed, under the direction of the Chairman of the Welfare Committee.

It is going to cost some money. Why is a full-time paid executive (a physician, if he can be obtained) necessary, and it is absolutely necessary? This work can never be carried on again by just a group of men. We have realized our limitations. The so-called "Christian Scientists" taught us this. There should be a man, an educated man, whose duty should be to represent the profession at all times. When a statement appears in the public press that is derogatory to the medical profession or derogatory to the individual doctor, in any county or city of the State, that man should immediately, after learning the facts, appear in the office of that paper and say, "Here is a statement." That is what the Christian Scientists do. Just notice that, if you will. When anything is said against Christian Science, it is answered the next day. If that is necessary for a small group in a religious movement, it is certainly much more important for the great medical profession, which is constantly being misrepresented.

Let me give you an instance: Two doctors in this State were sued for a large sum of money and the heading of one of the most reputable papers in this State read: "*Railroaded off to the Asylum.*" When it came to trial, the judge immediately nonsuited the case, there was no evidence whatever. Yet in the districts in which these men live, there are thousands of people today who believe those two fellows tried to get rid of a woman by sending her off to the asylum. If we had had a full-time, paid, educated man, he would have gone into the office of that newspaper the next day and

said, "Look here, this may not be actionable, but it isn't fair."

We circularized every newspaper in the State with a carefully prepared circular, asking them not to publish the account of a suit against a physician until it actually came into the court and pointed out the fact that they, the newspapers, were being used by a band of blackmailers, and that that was all their stock in trade. Even that circular had a very fine effect because I know of one case in which suit had been brought and lots of papers will not handle it, while the other papers (those that just want news and sensation) of course will print those things; they can't be stopped from doing so. But if we had somebody to go to every one of these papers the next day after a derogatory statement appeared in print, with a statement putting the physician and the profession right, something would be accomplished. And, gentlemen, we must have a systematic publicity campaign, not to tell how good we are, but just to tell the truth about us individually and collectively as a profession. If such a man is employed and he is a qualified man and does his job well, he will be the busiest man in the State of New Jersey inside of two months.

We had our last meeting last Sunday. We will have another one tomorrow night. We decided that we would introduce neither the Sterilization Bill nor the Marriage Certificate Bill again next year. Of course, I voted against that. I believe it is bad policy not to re-introduce them, but the other members of the Committee felt this way: That is we are going to try to do something with the Medical Practice Act, we should concentrate all our efforts on putting that over because, no doubt, we had too many bills this year. There is a good deal to be said in favor of that. So we make these recommendations: That the Medical Society of New Jersey endorse the principle that the work of the Welfare Committee be continued; that bills be introduced to put teeth into the Medical Practice Act; that the Society endorse the recommendation of Governor Silzer about the survey of education and that we try to get a doctor to do the surveying of the health education; and lastly, but most important, that this House of Delegates recommend to the Board of Trustees that sufficient funds be appropriated so that whoever is Chairman at that time can carry on this work successfully.

Vice-President MacAlister: You have

heard Dr. Eagleton's report, what is your pleasure?

Secretary Morrison: Before that motion is put, Mr. Chairman, I would like to say a word. It seems to me that this is a rather radical move. It is a move that is going to involve the outlay of ten or twelve thousand dollars, in addition to our present expenses. It is all right for the members of the House of Delegates to come down here and pass such a motion, if they feel they have the entire, consistent backing of the component societies in this move. This year there has been a big campaign made for new members. We have found out in the past, when various things were proposed, that the amount of money asked for was given willingly and cheerfully. We don't know that it will be now. It seems to me we might let this thing sink in for a while. Let the delegates digest this matter, and then bring these recommendations up for discussion say the last day of the session so that we can talk about them more intelligently.

Dr. W. B. Johnson: Mr. Chairman, we have a very representative meeting of the House of Delegates right now and I think we might discuss the matter at this time. The question of whether we shall spend eight thousand, or ten thousand, or twelve thousand dollars to carry out the recommendations of our Welfare Committee isn't so very material. There is no doubt about the fact that with Dr. Eagleton away, we will be placed in a position where the work of the Welfare Committee will not be as effective as it has been heretofore. We feel that the Society needs this Committee, and that it should be continued. We feel that the economic operation of the medical profession of the State of New Jersey is materially assisted by the operations of this Committee. I don't think there is a question about that. I don't believe there is a member of a component society who does not feel that we need this protection, that we need this Committee, and I doubt very much whether there is any one who does not think that we ought to have somebody thoroughly and absolutely qualified to take up this work. We have heard the report of the Committee. We know what we need. We know the difficulties that are facing us and I believe now is the time to take action.

Dr. F. W. Pinneo: I rise to second the suggestion of Dr. Johnson. No one who has not been in close association with Dr. Eagleton appreciates half of what Dr.

Eagleton has given to the State Society and to the profession of the State. He has given absolutely unselfish service, which has cost him money, time, and energy and which has stirred up opposition against him because you know, men, that you cannot do a thing that moves the world without meeting friction and opposition, but it is that that accomplishes the results. After a great deal of deliberation the Committee decided that the only way in which this work could be carried on was through a full-time paid executive, as Dr. Eagleton has suggested, so that the full time of somebody not in the practice of medicine (although he might be a physician, though that is not necessary) would be given to the interests of the State Society day and night, summer and winter.

You cannot appreciate, until you have been in this work and have gone into the matter of legislation, how much attention it demands, and how much knowledge you must have of things that are going on in the minds of others, Legislators, politicians, and political parties. We have a prestige which has been established very largely in the last three years, but we don't forget the work of Dr. Harvey and his predecessor, now dead, Dr. Halsey, and others. We are in danger now of losing that prestige if we don't carry the work on.

Dr. D. C. English: I wish also to second Dr. Johnson's suggestion. I think that there is no question about the money. With \$7,000 cash in hand today, with \$14,000 invested, with a \$5 assessment this year bringing in over \$10,000, there is no question but what there will be money enough, and there is really absolute necessity for carrying this work on in the way that has been suggested.

Dr. J. M. Rector: I am heartily in favor of everything that the Welfare Committee has asked, but I am certainly not going to sit in this assemblage and tell you to spend every darn cent you feel like spending. If Dr. Eagleton wants the Committee to have a paid executive, it seems to me the Committee should come in with a recommendation as to what they propose to pay that executive. It seems to me that if the members of the Welfare Committee would tell this meeting how much it is going to cost to carry on their work, in total, we could then tell exactly how to vote upon this subject.

Dr. W. B. Johnson: Mr. Chairman, this matter will be left entirely in the hands of the Trustees of this Society and I believe

that this House of Delegates can leave it to the Trustees of this Society not to throw away any money.

Dr. McBride: I want to say if there is any doctor in the State Society who doesn't know what the Welfare Committee has been doing, I rather feel that he hasn't been very wide awake. I am sure that every doctor ought to know of the work of that Committee, and I am quite confident if the Welfare Committee hadn't performed the duties that they have during the past two or three years, this Society would have been very much worse off. I believe that much legislation would have been passed that this Committee has prevented from passing; and I believe that to defeat any of the recommendations made by Dr. Eagleton would be a step in a backward direction.

President Eagleton: I ask you to see to it that this work that those of us who have been on the Committee have put our blood in is not allowed to die simply from inanition; and that whoever does take on the work, on whose mantle this responsibility falls, shall have adequate help to carry it through.

Vice-President MacAlister: The question is on the original motion, that the report of the Welfare Committee as submitted by Dr. Eagleton, be adopted, and that there commendations be concurred in in their entirety. All those in favor say "aye," contrary, "no." The motion is carried.

President Eagleton resumed the chair and said: The next order of business is the report of the Committee on Health Problems in Education, by Dr. Haight.

HEALTH PROBLEMS IN EDUCATION.

Dr. Harry W. Haight: As we understand the situation in regard to this Committee, it is a special committee which was appointed to take the place of a regular committee discontinued a year ago. On this Committee there are serving Dr. Clara Bartlett of Atlantic City, Dr. McGuire of Trenton, and your humble servant, Dr. Haight of Highland Park, New Brunswick. Perhaps in the beginning I should say a word in regard to the purpose of this Committee. We believe that Dr. Hunter in addressing a large educational meeting held in Newark two years ago expressed the purpose of this Committee very well when he said: "The medical profession of New Jersey wants the New Jersey school children to have the best chance for health that any group of children have any place in the

world." That is the thing we have been trying to give the New Jersey children. It may seem as though the purpose of the Committee are entirely altruistic. When the Committee was formed, we are very sure that they were, but possibly material interests have developed in the investigation of this problem as it has gone along. The Committee is pleased to report progress as follows:

For the committee's report, see the July Journal, page 236.

Dr. W. B. Johnson: I move that the report be received and that the recommendations be referred to Business Committee.

President Eagleton: It is moved and seconded that the report be received and the recommendations be referred to the Business Committee. Of course, the application for money will go to the Board of Trustees.

The motion was adopted.

There being no further Committees to report, we will pass to Unfinished Business. Is there any Unfinished Business?

Dr. J. N. Bassin: You heard the report of Dr. Eagleton. It seems to me that the work of the Welfare Committee is getting a little top-heavy. Some two or three years ago, when the survey of the Workmen's Compensation operations in this State was made, I think we were instrumental in helping Dr. Eagleton to get a line on some of the things that he had no time for. Since that time there has been talk on various occasions with regard to having the State Society appoint a Committee on Industrial Medicine and Surgery. While it is in a sense the work of the Welfare Committee, it occurred to me that until arrangements as to the management of the work in the absence of Dr. Eagleton have been made, it might be a good idea to have such a Committee and I would recommend that such a Committee be appointed: A Committee on Industrial Medicine and Surgery. We have made several efforts in this State to have a chapter of the Industrial Physicians and Surgeons, and we have failed. We haven't any section in the Northern Academy of Medicine. I think it is only right and proper at this time that such a committee should be appointed, in view of the amended Workmen's Compensation Act which becomes operative next month.

COMMITTEE ON INDUSTRIAL MEDICINE AND SURGERY.

I therefore offer a resolution that a Committee on Industrial Medicine and Surgery be appointed by the Chair to study the sub-

ject and to recommend a scientific revision of the present schedule of Workmen's Compensation disabilities, including eye injuries; second, to help standardize disability estimates in traumatic and occupational fields, in accordance with the newly amended Workmen's Compensation Act as it becomes operative July, 1924.

Dr. N. L. Wilson: Before that motion is put, I should like to hear from Dr. McBride, as to whether he is satisfied with the present condition of affairs, or whether he thinks that is an Association matter, or not.

Dr. McBride: Mr. President, I don't see that it can do any harm to have such a Committee. Any light that might be thrown upon our work would be welcomed by our Department, and if a Committee is appointed by the Society to help us administer our Compensation Laws, we would welcome their assistance. Of course, of their function would be simply to disturb things, we wouldn't welcome them. But I don't see how any Committee appointed by the Medical Society could do anything but help.

Dr. W. B. Johnson: Mr. Chairman, it seems to me that if such a committee were appointed to study the question, that would be sufficient for the Committee to do. If there is legislative action to be taken, I think that Committee should make its report to the Welfare Committee (make it a sub-committee, if you like, of the Welfare Committee, and let them report in such a way that that Committee, the Welfare Committee, can take up any question of legislation).

President Eagleton: I think that is provided for in the By-Laws. That is what would happen. You know, we had the same thing happen during this last session. One of your sub-committees ran amuck and the Welfare Committee had to tell it that it had to mind its own business, that as far as legislative matters were concerned the Welfare Committee was absolutely in charge. Then the Committee immediately withdrew its activities.

Dr. Harvey: Mr. President, the criticism that occurs to me on this resolution is that there is too much of it. It is all right to have a committee to make a study of the Compensation Law of the State, but the whole subject of industrial medicine and surgery should not come under consideration. I don't think that Committee should have power to institute any action. They could study it and report to us and the matter could then be referred to the Welfare Committee, but I don't think

they should interfere with the work of the Welfare Committee.

Dr. J. N. Bassin: I think there is a misunderstanding here. This resolution does not give the Committee any power to act or legislate or help legislation. This Committee simply be appointed by the Chair to study two features of the Workmen's Compensation Act as they will apply after July 5th, next. First is to simply revise the schedule which is antiquated and which has never been revised. I mean the scientific (medical aspect, not the legal. The second thing is, as far as possible, to arrive at some standard of disability, simply to help the Commissioner of Labor, or any one else. The Committee will have no power at all; it will just make recommendations to this Society. Then if the Welfare Committee, or any other Committee, wishes to take action, it is up to the Chair to decide whether they shall or shall not. However, there is no power vested in this Committee at all. But the subject must be studied; it must not be left to laymen, and it is not fair to ask the Department of Labor and the Commissioner of Labor to go into these details because he has his hands full already.

Dr. F. W. Pinneo: Mr. Chairman, I move this amendment to the motion: That it be reported back to the Welfare Committee. The Welfare Committee will no doubt welcome any committee that Dr. Bassin would like to have formed to study the matter. But let them report to the Committee, instead of waiting until next year to report back to the Society.

Dr. John N. Bassin: I accept the amendment.

President Eagleton: The motion then is that we adopt this resolution and that the report of the committee be submitted to the Welfare Committee. The motion was adopted.

President Eagleton: Is there any other miscellaneous business? If not, we will proceed to the reading of the names of the Nominating Committee.

Secretary Morrison then read the names of the Nominating Committee, representing county societies, three had no members present.

Drs. W. P. Conaway, G. H. McFadden, N. W. Newcomb, A. H. Lippincott, Chas. Sharp, E. W. Murray, John Nevin, J. J. McGuire, T. W. Bebout, W. H. Lucas, R. M. A. Davis, Lancelot Ely, S. T. Quinn.

Drs. O. H. Sproul and D. C. English were subsequently appointed.

Dr. D. C. English reported that the Fellows had chosen Drs. H. B. Costill, C. R. P. Fisher, W. B. Johnson, N. L. Wilson and Alexander Marcy as their representatives on the Nominating Committee.

President Eagleton: We will now have a paper by Dr. Edgar A. Ill of Newark, on "*The Palliative Treatment of Cancer of the Uterus and Cancer of the Breast.*"

Dr. Edgar A. Ill presented his paper on this subject. It will be found in the August issue of the Journal, pages 243 to 248, with its discussion by Drs. Stevens, E. Shields and E. A. Ill.

President Eagleton: We will now hear a brief address, "Post Graduate Work for Rural Physicians," by Dr. Alexander MacAlister.

Dr. MacAlister presented his paper.

President Eagleton: The discussion will be opened by Dean Meeker of Philadelphia.

Dr. Alexander MacAlister: I want to state, Mr. President, that Dean Meeker had to leave on the 4.50 train. He was sorry he was unable to remain any longer and requested that he be permitted to send his discussion to the Journal later to be inserted with the paper.

This paper will appear in the October Journal.

President Eagleton: If there is no objection, the discussion when submitted by Dean Meeker will be printed as having been delivered.

Dr. MacAlister: Mr. President, I would like to move that the Medical Society of New Jersey approve in principle the idea of university extension graduate medical education in New Jersey, and refer the matter to the Trustees with the request to take up with the Dean of the Graduate School of Medicine of the Universities and report an approved plan.

The motion was adopted.

An interesting surprise social program was observed in Vernon Room, Haddon Hall, at 8.30 P. M.

FRIDAY MORNING SESSION.

June 6, 1924.

The meeting convened at 9.50, Dr. Wells P. Eagleton, President of the Society, presiding.

President Eagleton: We will have the report of the Business Committee.

Dr. D. F. Weeks of Somerset County, presented the report of the Committee on Business as follows:

Report of the Business Committee.

Minutes of the Business Committee Meeting,
held June 6, 1924, at Haddon Hall,
Atlantic City.

The Business Committee reports that after careful consideration of the resolutions referred to them,

1. It is the judgment of the committee that the resolutions submitted by the Health Committee should be referred to the Welfare Committee for such action as they may deem necessary.

2. The resolution relative to periodic health examinations is recommended for adoption.

3. The resolution adopted by the Trustees instructing the Delegates to the A. M. A. is recommended for adoption.

David F. Weeks,
G. Howard McFadden,
W. Blair Stewart.

The resolutions above referred to are:

Resolution offered by the Committee on Health Problems in Education.

1. This Committee recommends that a vote of thanks and appreciation be extended to Hon. John Enright, State Commissioner of Education, Mr. Shaefer and Mr. Strahan, Assistant Commissioners of Education, Miss Lillian Anderson, Attorney for the State Department of Education; Senator Morgan F. Larson of Perth Amboy; Assemblyman Thos. L. Hanson of Perth Amboy; Assemblyman Harold G. Hoffman of South Amboy and Assemblyman Fred W. Devoe of New Brunswick for services in drawing up the bills and encouraging the progress of school health work, and that the Secretary notify them to that effect.

2. Resolved, That the members of the Medical Society of New Jersey, assembled in Annual Meeting at Atlantic, June 5th-7th, 1924, highly commended the initiative of Governor Silzer in recommending to the Legislature the appropriation of \$75,000.00 be made for the purpose of allowing him to appoint a commission of nine and to secure experts to make a survey of the Public School System. We strongly recommend to the Legislature that such a survey be made, but with the promise that at least one of the commissioners be a competent medical man; that he have charge of the survey of the school health program; that at least one-ninth of the funds appropriated be used for this purpose. The committee also recommends that the Welfare Committee be instructed to further this action on the part of the Governor and the Legislature.

3. A second contingency should be provided for in case that either house of the Legislature is publically opposed to the Governor and that the survey probably would not be made. In that event the committee would recommend that the Welfare Committee be instructed to hold a meeting on Public School Health, by December 1st, 1924, similar to the meeting held on the Workman's Compensation Act, attempt to evolve and promote legislation which will help to remedy the existing situation.

4. Appropriation for the expenses of the Committee.
Expenses incurred in 1923-24.....\$125.00

Estimated expenses for 1924-25.....\$125.00

The Business Committee recommended that these resolutions be referred to the Welfare Committee.

Resolution offered by the same committee.

Whereas, The American Medical Association and the several health associations of America at the instigation of Dr. Haven Emerson have endorsed the plan now known as the Periodic Health Examination, and whereas, the Welfare Committee of our State Medical Society during the interim has gone on record in favor of the plan, be it resolved that the Trustees of this Society heartily indorse this movement and that the same be urged for adoption by the Medical Society of New Jersey.

Resolution referred to the Business Committee and recommended by them to the Trustees for adoption.

Resolution referred by the House of Delegates to the Business Committee.

Resolved, That the Delegates to the American Medical Association, from the Medical Society of New Jersey be instructed to use their influence and votes to disassociate the Editorship and General Management of the Association, placing the Editorship entirely separate from the General Management of the Association. The Editor should devote his whole time to the scientific and ethical aspects of the profession, not to its business; and,

2. They use their influence and vote that an ad interim meeting of the House of Delegates be held at the headquarters of the Association annually. It is impossible for the House of Delegates to do their duty to the Association by having meetings but once a year.

Referred by the Business Committee to the Board of Trustees for adoption.

President Eagleton: You have heard the reading of this report; what is your pleasure?

Dr. D. C. English: I move that the report be received and the recommendations adopted.

President Eagleton: It is moved and seconded that the report be accepted and the recommendations adopted. So that there will be no misunderstanding whatever about this resolution instructing the Delegates to the American Medical Association, I am going to ask the Business Committee Chairman if he will read it. It was passed by the Board of Trustees.

Dr. D. F. Weeks: Before reading it, I might say that the Business Committee understands this resolution is to be presented as the official action of this Society instructing our own Delegates, is to be presented to the American Medical Association also?

President Eagleton: Yes, it is to be presented to the House of Delegates of the A.

M. A. as the official action of this Society, by our Delegates.

Dr. D. F. Weeks read the resolution as above given.

President Eagleton: You have heard the reading of the report of the Business Committee. It has been moved and seconded that the House of Delegates accept the report and approve the recommendations. Is there any discussion? If not, all those in favor will signify by saying "aye," contrary-minded, "no." It is unanimously carried.

Is Dr. Carrington in the room? We will have then the report of the Credentials Committee.

REPORT OF COMMITTEE ON CREDENTIALS.

Dr. W. J. Carrington: So far, there have been 139 Permanent Delegates registered. One of the unfortunate things that appears to the Corresponding Secretary is the fact that only 37 Annual Delegates out of 101 have registered. I think we can get a lesson from that, namely: We can recommend to the county societies that they exercise greater care in the selection of their Annual Delegates. I think the average county society nominates whoever they want to honor, irrespective of whether the men expect to attend the State Society meeting or not. That registration of 37 out of 101 is a poor showing. There are 84 associates thus far registered. One of the bright spots in the Registration Bureau is the fact that we have a number of other States represented by visitors. Pennsylvania has 7; Georgia, 1; District of Columbia, 2; West Virginia, 1; Ohio, 2; New York, 2; Illinois, 1; South Dakota, 2. The total registration up to a few moments ago was 655. Of course there will be more registered later.

Dr. D. F. Weeks: How many Permanent Delegates were there registered?

Dr. Carrington: One hundred and thirty-nine, of the total number of one hundred and sixty-seven. That is a very good record.

Dr. W. B. Johnson: How many did we have last year?

Dr. W. J. Carrington: Seven hundred and thirty-four. We will go over that this year, I think. See later report, page 33.

Secretary Morrison: May I make a few remarks in this connection? Dr. Carrington has just called attention to the fact that we have a large number of representatives from other States present at this meeting to hear the deliberations. Last November it was

one of my duties as Secretary to attend the Conference of Secretaries of all the State Societies held in Chicago under the auspices of the American Medical Association. The President was with us, and the Editor of the Journal. On the way home we questioned whether we of New Jersey had derived any benefit for the sacrifice of time in attending that conference. On thinking it over since, I have concluded that there was a great deal in it for some of the other States, if not for New Jersey. New Jersey has the oldest Medical Society in America. Many of the other societies are children in their experiences, as compared with the experiences of New Jersey. In the time that has elapsed from November up to the present, I have received and answered nineteen letters from different States. Four of five of them asked for our Constitution, which I had to have typewritten in order to send it to them, copies of our By-Laws, instructions as to what our Welfare Committee was doing, instructions as to what we are accomplishing along the lines of legislation, inquiring about our attitude toward cults, inquiring about our attitude toward osteopaths in particular, inquiring about our amendment to the Compensation Act, and how it is working out, and inquiring as to our protective insurance policy. So it shows that what we are doing in New Jersey is spreading and the other societies are receiving a great deal of benefit from our work. In this way, that conference was of considerable importance.

Dr. D. C. English: Dr. Carrington has referred to the small number of Annual Delegates from the county societies in attendance at this meeting. I think the custom has been too much in the past for the Delegates of the county societies to delay coming until about Friday, the second or third day of the meeting. I think the attention of the county societies should be called to the fact that it is important that those delegates attend earlier in the session. For instance, two or three counties yesterday had no representation on the Nominating Committee; nobody was here representing those counties. The delegates from the county societies should be here the first day, and I speak of that so that in the future the county societies will appoint delegates who will attend the sessions early, and stay through the entire meeting.

President Eagleton: Dr. J. Roemer of Paterson will present a paper on "*Röntgen Ray Therapy in Hemorrhagic Metropathies and Uterine Myomata*"

Dr. Roemer presented his paper on this subject, which was published in our August Journal, pages 249 to 253, with the discussion by Drs. E. A. May, J. T. Stevens, E. A. Ill and J. Roemer.

President Eagleton introduced Dr. F. W. Pinneo who presented a paper on

"Manual Artificial Respiration for Resuscitation."

It was discussed by Drs. R. R. Sayres, D. Strock, F. R. Haussling, M. Runyon, A. J. Mitchell and F. W. Pinneo.

This paper and its discussion will appear in the October Journal.

President Eagleton: I wish to call the attention of the members to the note on the program in connection with this paper. "In Room A, directly off Vernon Room, demonstrations will be given before and after each session of the Convention, of Manual Resuscitation, as described in Dr. Pinneo's paper." Therefore, every member will have an opportunity to see this method in operation at his convenience.

I am now going to call on Dr. E. J. G. Beardsley of Philadelphia, Associate Professor of Medicine at the Jefferson Medical College, for the "Oration in Medicine."

There are very few men that occupy a position such as Dr. Beardsley occupies who are more loved by the men of Southern Jersey than Dr. Beardsley. I never had the pleasure of meeting Dr. Beardsley until today, but I received a large number of letters from South Jersey (I want to say this to his face) after he had been selected, and from the tone of those letters I inferred that he is loved by all the men who have been under him. I take great pleasure in introducing Dr. Beardsley.

Oration in Medicine.

For this oration see pages 275 of this issue of the Journal.

Dr. W. G. Schauffler: Mr. President, I move a rising vote of thanks to Dr. Beardsley for his very instructive and helpful oration.

The motion was adopted by a unanimous rising vote.

FRIDAY AFTERNOON SESSION.

June 6, 1924.

The meeting convened at 2.30, Dr. Wells P. Eagleton, President of the Society, presiding.

President Eagleton: I wish to announce that this is a meeting of the House of Delegates alone. This is not an open scientific meeting. Dr. Whiteside's address, which will be the first open item on our program this afternoon, will be announced in the cor-

ridors. But this is a meeting of the House of Delegates and only delegates will be allowed to remain. All members of the Society are entitled to remain, but only delegates to the House of Delegates can vote. I will ask that the doors be closed. If there are any persons present who are not members of the Medical Society of New Jersey in good standing, they are invited to retire. No matter what may occur at this meeting, it is the bounden duty (and I want to put it exactly that way) of every member of this Society not to discuss anything that transpires here outside, for it has nothing whatever to do with anybody except members of this Society. We have found in legislation that our chief enemy has been the doctor himself. He has gone behind our back and told things that were not true, or things that were his own individual opinion, and what he wanted to happen. That is his prerogative in matters of public affairs. This is our business alone.

Dr. John Nevin: I have been to a great many meetings of the State Medical Society and I have been obliged at times to listen to a lot of discussion that was not only uninteresting, but unnecessary. I wish, therefore, Mr. President, to make a motion that the discussion today on any subject be limited to five minutes and that no member be allowed to discuss the same question twice.

President Eagleton: All those in favor of this motion signify by saying "aye," contrary-minded, "no." It is so ordered.

According to Section 4, Chapter V. of the By-Laws, "The report of the Nominating Committee, and the election of officers, standing committees, councillors, delegates to the American Medical Association, and delegates to State Medical organizations for the ensuing year shall be the first order of business of the House of Delegates in the afternoon of the second day of the Annual Meeting." Hudson County has a permanent delegate whose credentials have been properly filed, but through an inadvertence or misunderstanding, they were not acted on at the regular time yesterday. With unanimous consent, he can now be nominated and take his seat in the House of Delegates.

Dr. Johnson: What is his name?

Secretary Morrison read a statement certifying that Dr. Reeve L. Ballinger had been nominated as a Permanent Delegate from Hudson County.

Secretary Morrison: That was an error on the part of the county society in not reporting to this body the death of Dr.

Mooney who had been elected a Permanent Delegate.

President Eagleton: What is your pleasure?

It was voted, upon motion regularly made and seconded, that Dr. Ballinger be elected as a Permanent Delegate from Hudson County.

President Eagleton: We will now have the report of the Nominating Committee.

REPORT OF THE NOMINATING COMMITTEE.

Dr. Lancelot Ely: At the meeting of the committee held June 5th, Dr. W. B. Johnson was elected chairman and I was elected secretary. The committee decided to make the following nominations:

President, Alexander MacAlister, Camden; First Vice-President, Archibald Mercer, Newark; Second Vice-President, Lucius F. Donohoe, Bayonne; Third Vice-President, James S. Green, Elizabeth; Corresponding Secretary, William J. Carrington, Atlantic City; Recording Secretary, J. Bennett Morrison, Newark; Treasurer, Elias J. Marsh, Paterson.

Trustees: Fourth District, Paul M. McCray, Camden; Fifth District, J. H. Underwood, Woodbury.

Committee on Publication: Chas. D. Bennett.

Committee on Scientific Work: Ralph K. Hollinshead.

Committee on Standardization of Hospitals: G. N. J. Somers, Howard S. Forman.

Committee on Public Health and Sanitation: Thomas B. Lee, Henry Spence.

Committee on Program and Arrangements: William D. Olmstead.

Delegate to the American Medical Association: Wells P. Eagleton.

Alternate Delegate: Philip Marvel.

Delegate to the Pennsylvania State Society: H. F. Palm.

The Nominating Committee recommends Atlantic City as the next place of meeting, the final decision to be referred to the Board of Trustees.

This report is signed by Walter B. Johnson, Chairman and Lancelot Ely, as Secretary. The report was, on motion, received.

Dr. Fred J. Quigley: Mr. President, while it is an unusual procedure for nominations to be made from the floor, I desire to exercise my rights as a delegate to place in nomination for the Presidency of this Society the name of the present Second Vice-President of the Society, Dr. Archibald Mercer of Essex.

Dr. E. G. Wheery: I second the nomination of Dr. Archibald Mercer for President.

Dr. Alfred Stahl: I move that the nominations for president be closed.

President Eagleton: It is moved that the nominations for President be closed. All in favor signify by saying "aye," contrary-minded, "no." The "ayes" have it.

We will now proceed to ballot, according to the Constitution, for the office of President of the Medical Society of New Jersey. Section 1, Chapter V. of the By-Laws state: "All elections shall be by ballot and a majority of the votes cast shall be necessary to elect." We will proceed to ballot and only those who are members of the House of Delegates can vote.

Dr. David A. Kraker: I move that you appoint four tellers. It was carried.

President Eagleton: I will appoint as tellers Drs. E. D. Newman, A. Haines Lipincott, B. S. Pollak and C. A. Rosewater.

President Eagleton: We will call the roll by counties and the men will come forward with their ballots when their names are called.

Balloting for the President took place, according to counties.

President Eagleton: We will now call the roll of the Fellows and the Officers and if they have not voted in some county, they will vote now, or decline, as they please.

The balloting for President continued, the Fellows, Officers, Trustees, Councillors, and Chairman of Standing Committees casting their ballots at this time.

President Eagleton: Are there any members of the Society who have not voted who think they have a right to vote? If not, the ballot is now declared closed. The tellers will count the ballots.

The meeting took a recess for five minutes.

President Eagleton: The Society will come to order. I will again ask if there are any persons present who are not a member of the Medical Society of New Jersey in good standing. If there are I wish they would withdraw.

The tellers will now announce the vote.

Dr. Emanuel D. Newman: There were 173 votes cast. Dr. Mercer received 117; Dr. MacAlister 54; there were 2 blanks. That totals 173.

President Eagleton: The Chair declares Dr. Mercer of Essex County, elected the President for the ensuing year.

Dr. W. B. Johnson: Mr. Chairman, I wish to offer a motion that the election of Dr. Mercer be made unanimous.

Dr. H. B. Costill: I second that motion.

President Eagleton: The motion is that

the election of Dr. Mercer of Essex County as President, be made unanimous. Is there any discussion? If not, all those in favor of the election of Dr. Mercer unanimously will signify by saying "aye," contrary-minded, "no." Dr. Mercer is declared the President for the ensuing year by the unanimous vote of this Society.

Next in order is the election of the First Vice-President.

Dr. F. W. Pinneo: I nominate as First Vice-President, Dr. Lucius F. Donohoe of Bayonne.

President Eagleton: It is moved and seconded that Lucius F. Donohoe of Hudson County be elected First Vice-President. Are there any other nominations?

Dr. F. W. Pinneo: I move that the Secretary cast the ballot for Dr. Donohoe for First Vice-President.

President Eagleton: It is moved and seconded that the Secretary cast the ballot for Dr. Lucius F. Donohoe. Are there any objections? If not, the Secretary will cast the ballot for First Vice-President.

Secretary Morrison: The ballot has been cast for Lucius F. Donohoe of Bayonne for First Vice-President.

President Eagleton: Dr. Lucius F. Donohoe is declared elected First Vice-President of the Medical Society of New Jersey. Next in order is the election of the Second Vice-President.

Dr. A. Haines Lippincott: I nominate Dr. James S. Green of Elizabeth.

President Eagleton: It is moved and seconded that the name of Dr. Green of Elizabeth be placed in nomination for Second Vice-President, and that the Secretary be instructed to cast the ballot for Dr. Green. Is there any discussion? If not, all those in favor of this motion signify by saying "aye," contrary-minded, "no." It is so ordered.

Secretary Morrison: The Secretary has cast the ballot for the election of James S. Green of Elizabeth for Second Vice-President.

President Eagleton: I hereby declare Dr. Green elected Second Vice-President of the Medical Society of New Jersey for the ensuing year.

We will now elect the Third Vice-President.

Dr. Marcus W. Newcomb: I move the nomination of Dr. Walt P. Conaway of Atlantic City for Third Vice-President.

Dr. Larcelot Ely: I would place in nomination the name of Dr. David F. Weeks of Skillman.

President Eagleton: The Chair rules that the election between Dr. Conaway and Dr. Weeks shall be by ballot. Are there any other nominations?

Dr. A. L. Ellis: I would like to nominate Dr. McBride of Paterson.

Dr. A. F. McBride: I thoroughly appreciate the honor conferred upon me in naming me for this position, but I would much prefer that either one of the other gentlemen nominated be elected, and for that reason I decline. I am thankful indeed for the confidence reposed in me by my friends, but I feel at this time I would rather have Dr. Conaway or Dr. Weeks elected to this position.

Dr. G. Blackburne: I nominate Dr. Quigley for Third Vice-President.

Dr. Fred J. Quigley: I must decline. The activities I have taken in this thing this year would make it very embarrassing for me to be a candidate at this time.

President Eagleton: As Chairman of your Welfare Committee and President of your Society, I wish to say that I hope to cast my ballot for Dr. Quigley's election at some time, because of the great work that he has contributed to this Society as a member of the Welfare Committee. Drs. Conaway and Dr. Weeks are now the candidates before you.

There was a recess for five minutes while the balloting proceeded for Third Vice-President.

Dr. Elbert S. Sherman: Can we proceed with the election of the rest of the ticket, Mr. President?

President Eagleton: Surely. We will proceed with the rest of the nominations. First is the nomination for Corresponding Secretary.

Dr. Fred J. Quigley: Mr. President, I move that the remainder of the recommendations of the Nominating Committee be concurred in and that the Secretary be instructed to cast one ballot for the remaining officers and committees.

President Eagleton: And I would ask that the delegates and their alternates to the A. M. A. be instructed to carry out the declared policy of this Society, or not to accept the position.

Dr. F. W. Pinneo: Mr. President, there are Delegates and Alternates to the A. M. A., Delegates to the Pennsylvania Society to be elected. I move the Secretary be instructed to cast one ballot for the names submitted. All those in favor of the motion signify by saying "aye," contrary-minded, "no." It is so ordered.

Secretary Morrison: The ballot has been cast for the names as submitted by the Nominating Committee for these offices: (Read names submitted by Nominating Committee).

President Eagleton: These gentlemen are declared elected to the various offices mentioned.

President Eagleton: There is a motion before the house. It has been moved and seconded that the rest of the nominees as Officers, Trustees, Members of Committees and Delegates to the A. M. A. and Pennsylvania Society, as presented by the Nominating Committee be declared elected and that the Secretary cast the ballot for their election.

Secretary Morrison: The Secretary has cast the ballot for the election of said Officers, Trustees, Members of Committees and Delegates.

President Eagleton: I hereby declare these Officers, Trustees, Members of Committees and Delegates elected.

Secretary Morrison: There is one other recommendation from the Nominating Committee. They recommend that Atlantic City be the next place of meeting, the final decision to be referred to the Board of Trustees.

President Eagleton: You have heard the recommendations, what is your pleasure?

Dr. Wm. G. Schauffler: I move its adoption.

Dr. D. C. English: There is only one point there: It says that the place and date of meeting be referred to the Board of Trustees.

Secretary Morrison: The Constitution provides for that.

President Eagleton: The Constitution provides that the Trustees or House of Delegates shall decide the place of meeting.

Dr. Rogers: The Nominating Committee said Atlantic City should be the place of meeting.

President Eagleton: The Nominating Committee simply make a recommendation to the House of Delegates that it be referred to the Trustees, but this body, the House of Delegates, or the Board of Trustees have to decide where we shall meet, and the time.

Dr. Wm. D. Olmstead: As a member of the Committee on Program and Arrangements, I move, sir, that the meeting be held next year at Atlantic City, in Haddon Hall, the time of meeting to be set at the convenience of the committee.

President Eagleton: It is moved that the meeting place be Atlantic City, the date, time and place in Atlantic City to be decided by the Committee on Arrangements. All those in favor of this motion signify by saying "aye," contrary-minded, "no." It is so ordered.

President Eagleton: We will now hear Dr. Pinneo's motion.

Dr. F. W. Pinneo: Mr. Chairman, my motion was that the State Society instruct the Delegates to the American Medical Association to carry out the will of the State Society as expressed in its action. I offer this, in order that the Delegates who go to the A. M. A. will know that what they stand for is endorsed by us, so that if a Delegate goes there he will carry out the expressed will of this Society, and the Society will be acting, as well as the individual.

President Eagleton: This not only applies to me and to Dr. Marvel, it applies to all Delegates to the A. M. A. How any man can think that he can go out there as a delegate from this Society and then voice an opinion that is contrary to the expressed wish of this Society, I cannot understand. I cannot understand how a Republican President can be elected and then say he believes in something that the Democratic Party had been fighting him on. We want loyalty to our Society first of all.

President Eagleton: Will you repeat it, although I presume we all know what it is?

President Eagleton: The motion having been duly seconded, all those in favor of it signify by saying "aye," contrary-minded, "no." It is so ordered.

We will now have the report of the tellers.

Dr. Emanuel D. Newman: There were 159 votes cast. Dr. Conaway received 103 Dr. Weeks 56. (Applause).

Dr. D. F. Weeks: I would like to have the pleasure of moving that the election be made unanimous for my friend and classmate, Dr. Conaway.

The motion was carried.

President Eagleton: Dr. Conaway is declared unanimously elected for Third Vice-President of the Medical Society of New Jersey for the ensuing year.

Dr. Walt P. Conaway: Mr. President, may I submit my resignation as a member of the Judicial Council of this Society?

President Eagleton: Dr. Conaway submits his resignation as a member of the Judicial Council of this Society.

Secretary Morrison: What district?

Dr. Coraway: The Fifth District.

It was regularly moved and seconded that Dr. Conaway's resignation as a member of the Judicial Council be accepted; the motion was carried.

President Eagleton: Nominations are in order to fill the vacancy.

Dr. Davis: I nominate Dr. W. P. Glendon of Bridgeton.

It was moved and seconded that the Secretary be instructed to cast the ballot for Dr. W. P. Glendon as Councillor from the Fifth District.

President Eagleton: You have heard the motion; all those in favor signify by saying "aye," contrary-minded, "no." It is so ordered and the Secretary will cast the ballot.

Secretary Morrison: The Secretary has cast the ballot for Dr. W. P. Glendon for Councillor from the Fifth District.

President Eagleton: Dr. Glendon of Bridgeton is declared elected Councillor of this Society from the Fifth District.

President Eagleton: Mr. Whiteside is the Counsel of the New York State Medical Society and as such for the last few years has had to do with the enforcement of the Medical Practice Act and the drawing up of bills to try to clear the medical atmosphere in New York State. His experience is very large, and I want to say to him in the presence of you all that he has been most courteous to us in trying to help your Welfare Committee solve the problems of New Jersey. And I believe he has presented us with a bill that after careful examination by Dr. Pinneo, Dr. Quigley, myself and the whole committee many times, we think is a very constructive piece of legislation and the best thing that was offered to us.

I take great pleasure in introducing Mr. Whiteside.

ENFORCING THE MEDICAL PRACTICE ACT.

(For Mr. Whiteside's address see the August Journal.)

Dr. Fred J. Quigley: I move a rising vote of thanks be given to Mr. Whiteside for his splendid address to which we have listened with rapt interest and attention.

President Eagleton: Gentlemen, you must understand that Mr. Whiteside brought to the study of the Medical Practice Act a trained, legal mind, and as far as we know, this is the first time that any one has undertaken to analyze the Medical Practice Act as it should be, defining its defects. We

are all tremendously under obligation to Mr. Whiteside for what he has done, and we thank him for coming here.

President Eagleton: We will now have a paper by Dr. M. J. Fine on
"Treatment of Pulmonary Tuberculosis by Artificial Pneumothorax."

Dr. Fine presented this paper in abstract. This paper will appear in the October Journal with its discussion.

At this point, Dr. Lucius F. Donohoe, Third Vice-President, assumed the Chair.

Chairman Donohoe: Dr. Alexander Armstrong. He will open the discussion.

FRIDAY EVENING SESSION.
 June 6, 1924.

The meeting was called to order by Vice-President Donohoe. He introduced the President, Dr. Wells P. Eagleton, who delivered his annual address.

PRESIDENT EAGLETON'S ADDRESS.

This address will be published in full in the Journal.

The meeting then adjourned.

SATURDAY MORNING SESSION.
 June 7, 1924.

The meeting convened at 10.15. Dr. Wells P. Eagleton, President of the Society, presiding.

President Eagleton: The meeting will come to order. We will call for the report of the Corresponding Secretary.

Dr. Wm. J. Carrington: The total registration is 827. That is the largest registration that this Society has ever had by almost 100. Last year it was 754.

The registration from the counties is as follows: Atlantic, 139; Bergen, 10; Burlington, 12; Cape May, 1; Camden, 44; Cumberland, 3; Essex, 150; Gloucester, 19; Hudson, 71; Hunterdon, 10; Mercer, 46; Middlesex, 10; Monmouth, 3; Morris, 17; Ocean, 7; Passaic, 38; Salem, 4; Somerset, 15; Sussex, 2; Warren, 9; Union, 22.

There are 87 exhibitors and 24 representatives of other States as follows: Pennsylvania, 9; New York, 4; District of Columbia, 4; West Virginia, 2; South Dakota, 2; Georgia, 1; Ohio, 2; Illinois, 1.

We had one official representative of the American Medical Association.

Every county was represented.

Out of 203 Permanent Delegates, 146 were present.

Out of 101 Annual Delegates, 44 were present. One hundred and twenty-eight

Associates of the Medical Society of New Jersey were present. All of the seven officers registered and 32 out of 36 Trustees were present.

While that registration of 827 is unprecedented, it does not represent enough doctors. The total physicians (that is, New Jersey physicians) registered was 318, and that is almost 100 more doctors than have ever been here before, but still that is not enough.

Dr. D. C. English: I move the report be accepted.

President Eagleton: It is moved that the report be accepted and that it be published in the Journal as part of the official transactions of the Society. All those in favor of this motion signify by saying "aye," contrary, "no." It is so ordered.

Dr. D. C. English: I would like to present the report of the Board of Trustees.

Dr. English then presented the final report of the Board of Trustees, as follows:

Report of Board of Trustees.

The Trustees met in Haddon Hall at 1 P. M., June 6, 1924. Chairman Sproul presided.

The resolution referred to the Board by the House of Delegates which would allow the Secretary of the Society to employ a paid assistant was discussed and adopted, and it was decided that the amount to be paid said assistant should not exceed eight hundred dollars without sanction of the Board of Trustees hereafter.

Another resolution referred by the House of Delegates, in favor of University Extension Graduate Medical Education in New Jersey, after favorable consideration, was, on motion, referred to the Welfare Committee for its action.

The following bills referred to the Trustees were, on motion, approved and ordered paid. Bill of the Judicial Council for expenses incurred \$137; bill of the Orange Publishing Co. for reprints of Dr. Sherman's Report, \$8.00

The Board then adjourned.

David C. English, Secretary.

Dr. Wm. G. Schauffler: I move the report be accepted.

President Eagleton: I will say that the consideration of the Post-Graduate Course was referred to the Welfare Committee because the Welfare Committee had some time ago taken up an investigation of this subject and had gone quite a little way with it; so they thought it was not a good idea to create a new committee. As Dr. MacAlister has given some attention to this matter, I will gladly make him the chairman of the sub-committee of the Welfare Committee to take this matter in hand, if he will accept the position.

All those in favor of accepting this re-

port signify by saying "aye," contrary-minded, "no." It is so ordered.

Dr. Alexander MacAlister: I would now like to make another report, from the State Board of Medical Examiners.

Dr. MacAlister then presented the report of the State Board of Medical Examiners, as follows:

State Board of Medical Examiners' Report.

Legislation.—During the last session of the Legislature the Board prepared and secured, with the aid of the Welfare Committee and especially of Dr. Quigley, the passage of a bill which provides that after September 1st, 1924, no school or college shall be conducted within the State of New Jersey for the purpose of training or qualifying its students to practice medicine or surgery of any branch thereof or any method of treatment of disease or any abnormal condition without first securing a license from the State Board of Medical Examiners. The purpose of the act is to prevent diploma mills and low grade schools from continuing to operate in New Jersey.

The Board prepared and had introduced a bill to require internes and resident physicians in the hospitals to secure a permit from the Board. The purpose of this bill was: (a) To protect the people of our State while in the hospitals. In checking official lists from Connecticut, of licenses revoked, the Board found that a number of men with practically no medical education had served as interns in New Jersey; (b) To enable the hospitals to secure internes with an adequate medical education; (c) To give the Board an opportunity to pass on the credentials of applicants before they begin their internship, which would enable the applicant to make up any deficiency in his medical work before serving his internship.

The Board did not prepare this bill to increase their income, but they estimated that there would be about a hundred internes each year, that it would entail an expense of at least a thousand dollars to investigate their credentials and inspect the hospitals to prevent violations of the act, and then made the fee ten dollars. The bill was later amended to change the fee to five dollars and to provide for deduction of the fee from the regular examination fee when the applicant applied for examination. As this was not satisfactory to all concerned the Board decided to withdraw the bill as they did not believe they would be justified in doing the additional work if the expense was to be deducted from the present receipts as all surplus funds were being used for prosecutions.

The annual registration bill was withdrawn at the request of the Welfare Committee. The bill to require applicants for a chiropractic license who received their training under the jurisdiction of the Federal Board of Vocational Training to have been citizens of New Jersey at the time they entered the service of the United States government and to require them to take an examination, was held in committee, at the request of the Welfare Committee, until the last week of the session and the Board was then unable to secure its passage. Another effort will be made to amend the 1923 amend-

ment during the next session and in the meantime the Board will take an appeal from the decision returned by the Supreme Court on the application of John A. Kinlin for a license without an examination.

The Welfare Committee and the Board, co-operating, secured the defeat of the Chiropody Bill because of the definition of chiropody it contained, and of the fact that it would have given them the right to use any drug not classified as a narcotic by the Federal Government in the Harrison act, and the right to use the title "Dr."

At the present time the Board has received thirty-eight applications from foreign physicians for the June medical examination, and others will probably be received. The amendment to the New York law which requires applicants to be citizens is, no doubt, in part responsible for the increase of foreign applicants in this State and the Board believes that citizenship (not excluded) should be required.

Prosecutions.—The following is a report of the prosecutions and investigations from June 15, 1923, to June 1, 1924, for Violation of Laws:

Violations of			
Med. Prac- tice Act	Midwifery Act	Chiropody Act	
Cases won	23	23	3
Cases lost	1	0	0
Cases non-suited . .	0	0	0
Decision withheld . .	1	0	0
Cases pending	24	13	3
Cases appealed . . .	0	0	0
Totals	49	36	6

Hearings Before the Board:		
	Physicians	Midwives
Suspended	8	1
Dismissed	0	1
Pending	1	3
Restored	0	1
Restoration refused	1	2

Referred for Investigation and Prosecution:	
Unlicensed physicians	69
“ chiropactors	60
“ chiropodists	10
“ midwives	15
Naturopaths	3
Druggists practicing medicine	4
Midwives practicing medicine	2
Unclassified practicing medicine	19
Midwifery non-registration	88
Chiropody non-registration	22
Midwives referred for revocation of licenses	11
Physicians referred for revocation of licenses	5
Unclassified investigations	11
Investigations pending June 15, 1923	27

During the past month three chiropactors have been tried on a second charge of practicing without a license, when found guilty they refused to pay the penalty of five hundred dollars and were sentenced to jail. In the Conover case of Union Hill, the sentence was for fifty days, in the Whiteside case in Trenton and the Frye case in Mt. Holly, the sentence was for only thirty days. The Board has been informed that the National Association of Chiropactors agrees to pay the convicted chiropactors two hundred and fifty dollars a month while they are in jail, but if they refuse to go to jail they must pay their own penalty. Therefore, when a chiropactor goes to jail he saves his penalty and also receives two hundred and fifty dollars

a month, which in some cases is, no doubt, more than he receives from his practice. Unless longer sentences are given in the cases now pending, the Board believes that the prosecution clause of the Medical Act should be amended to provide a sentence of not less than one hundred days or more than two hundred days, instead of the present provision of not more than two hundred days. It will then cost the National Association over seven hundred and fifty dollars if the defendant goes to jail.

During the past year the total receipts from prosecution have amounted to	7,098.89
Expenses have amounted to	6,261.58
(Up to present time.)	\$837.31

Receipts and Expenditures for Past Five Years—Prosecution Account.		
	Receipts	Expenses
1919-20	\$ 2,597.00	\$ 3,597.82
1920-21	3,348.00	4,024.18
1921-22	2,970.00	4,926.93
1922-23	5,413.13	4,066.30
1923-24	7,098.89	6,261.58
	\$21,427.02	\$22,876.81
Expenses during past five years have amounted to \$1,449.79 more than receipts.		

Dr. Wm. G. Schauffler: Mr. President, I move that this report be accepted and the recommendations approved.

Dr. W. B. Johnson: May I ask a question in relation to it? I understand that an interne in a hospital must be a graduate of an accredited college, according to the law. I would like to know how it is that an interne can get into a hospital through the Board of the Hospital, and serve in a capacity where he has the privilege to write death certificates, unless the Board that let him in is satisfied that he is properly graduated from an accredited medical college.

Dr. MacAlister: We have several instances, Dr. Johnson, on record where they did get in, two or three in North Jersey, and one right here in Atlantic City last year, at the Atlantic City Hospital.

Dr. F. W. Pinneo: I think we ought to express approval of what Dr. MacAlister has told us. The Board is going to appeal from the Supreme Court's decision, their upholding of the law. We should point out the need in this State Society of watching legislative activity on welfare matters, because this law is just like the iniquitous law of 1920, and if we can work to prevent the passing of these iniquitous bills we will be saved the onus and the difficulty of having to work for their repeal after they have gone through.

Dr. MacAlister: The Board thought it wise to appeal that because that simply will hold the matter up for another year and

give us an opportunity to get in an amendment this winter requiring an examination. Of course, there is a great deal of public sentiment against that, owing to the fact that these men served in the World War, but the Board does not think they should be permitted to practice without having met the requirements. The recommendation is that foreign physicians either declare their intention to or that they become citizens of New Jersey before they are allowed to come before the Board for examination.

President Eagleton: Is that not in the law today, Doctor?

Dr. MacAlister: No. That is just a recommendation, to have it inserted, this winter.

Dr. Wm. G. Schauffler: It is included in my motion, Mr. President, that the report be accepted and the recommendations be approved.

President Eagleton: The recommendation is that legislation be introduced at the next session requiring that foreign physicians declare their intention, or that they become citizens of New Jersey before they are allowed to come before the Board for examination. That is the condition in New York State.

Dr. Devlin: I would like, Mr. Chairman, to ask Dr. MacAlister a question. Has the State of New Jersey any reciprocity with foreign countries as regards the Medical Practice Act?

Dr. MacAlister: It has not, Doctor. We have no endorsement from a foreign country, not even from Canada.

Dr. Devlin: Then why do we allow foreign physicians to come into the State and practice medicine?

Dr. MacAlister: For this reason, Doctor: They are required to take the examination. If they come from a registered school abroad and their credentials are certified to by the Consul of the country, our Board accepts that and allows them to take the examination, providing they can meet the other educational requirements.

Dr. Devlin: Do they have to take the examination in English?

Dr. MacAlister: Yes, it is not given in any other way. Two or three years ago they were allowed to have interpreters, but that was amended, so that everybody who takes the examination before the Medical Board must speak and write English.

Dr. Devlin: I have been coming to the meetings of the State Medical Society for twenty-five years, and I have always noticed that the representatives of the Medical So-

ciety on the State Board are always locking the stable door after the horse has been stolen, practically speaking. The time to object to those men coming to practice medicine in the State of New Jersey that have no right to do so is now, not when they are in. And the State Medical Board, as I understand it, have a perfect right to object to their practicing medicine, and they should do so. It is their duty to do so. I cite one case. We have in Newark today a woman who advertises herself as an M. D. She states in her advertisement that she has been practicing medicine in Austria for seventeen years. If she had practiced medicine in Austria for seventeen years and she was any good, she wouldn't have left there. She would have stayed there. I think that the Board of Medical Examiners should object to these men coming into the State to practice medicine here unless they are American citizens.

Dr. James Hunter: I think Dr. Devlin has struck the keynote of the situation so far as the foreign practitioner goes, in reference to his being an American citizen. As I understand it, New York requires that, and I would like to ask Dr. MacAlister, through you, if our Board requires citizenship as one of the pre-requisites for practicing medicine.

Dr. Alexander MacAlister: Not at the present time.

President Eagleton: They haven't the authority according to the law. As I understand it, Dr. MacAlister's Board, very wisely, wants legislation next year to give them the authority to refuse to give these men a license unless they either are citizens of the United States, or express a desire to become such.

Dr. Alfred Stahl: I think the intention to become a citizen should be stricken out of that resolution; they should be citizens before they are given a license to practice.

President Eagleton: This discussion is of the greatest value. I wish personally to thank Dr. MacAlister for bringing these matters before this House of Delegates, and for rendering this complete report of the operations of the State Board of Medical Examiners, because anything that brings the medical profession in closer touch with the Board of Medical Examiners must be for the good of the whole profession and for the good of the community. In relation to what Dr. Devlin says, I will say that your Welfare Committee last year spent a great deal of time examining the Medical Practice Act, and we employed

Mr. George W. Whiteside. He is today under fee by the State Medical Society for the examination of this law. Yesterday's report was in the way of a preliminary report, the complete report of which I have in the files of the Welfare Committee. And his instruction is this: To put teeth in the Medical Practice Act. It was decided that to amend the whole Medical Practice Act would be to simply throw the Act into the political arena, and when we got through with the legislators we might be worse off than we are now. So it was decided—and this after a good deal of discussion—that this law should be examined by Mr. Whiteside, line by line. Then he is to take these parts that are weak and make them strong by amendments, which your Welfare Committee has instructed shall be done at the next session of the legislature. Does that answer your question, Dr. Devlin?

Dr. Devlin: Yes, sir.

Dr. Chas. J. Larkey: I would like to ask Dr. MacAlister whether some of the foreign counties issue licenses to practice without the doctor being a citizen of that country?

Dr. MacAlister: I think they do. I understand that if you go to Germany, you are allowed to put out a sign and to mark it, "American Physician" and are able to practice.

President Eagleton: That may be so, Dr. MacAlister, but a few years ago there was only one American physician in the city of Berlin, so it couldn't have been very general at that time.

President Eagleton: The motion is that the report be received and the recommendations concurred in by the Society. All those in favor of this motion signify by saying by saying "aye," contrary-minded "no." It is so ordered.

President Eagleton: Dr. Beling has a matter he wishes to present to the Society.

Dr. Christopher C. Beling: Mr. President, this is a report of the Committee on Medical Defense and Indemnity Insurance.

Dr. Beling presented the report of this committee:

REPORT ON MEDICAL DEFENSE AND INDEMNITY INSURANCE.

President Eagleton: You have heard the reading of the report, what is your pleasure?

Dr. Hunter: I move the report be received and ordered printed in the Journal.

This report will be inserted in the October Journal.

President Eagleton: It is moved and seconded that the report be received and be ordered printed in the Journal; is there any discussion?

Dr. W. B. Johnson: Mr. Chairman, I would like to say a word. I am a member of this committee, and I am very sorry that only 600 of our members up to this time have availed themselves of this privilege. I think that when the policies in other companies pass out, as a matter of loyalty to this Society, it would be very desirable for everybody to take out this insurance. It would probably lower the fees; it would benefit the Society; it would benefit the individual, because the individual would have behind him the weight of the Society of the State of New Jersey. I believe, too, that in due course our individual medical defense should be given up and the matter should be left entirely in the hands of the Society and the insurance company under the group insurance policy. There is no doubt about the stability of this policy, and there is no doubt about the desirability of every member being insured in this company, our company. It is our company for the time being. If some other company offers something better, then we can take it up with that other company and have our group insurance in that company if it is thought desirable. But for the time being, there is no doubt about the stability of this company and the desirability of every member in the Society being insured. It is a pretty sad thing when you are faced with a suit. I was sued for a quarter of a million dollars. I didn't know how they were going to get the quarter of a million from me, but in any event the case in due time was thrown out of court.

Dr. F. W. Pinnco: Mr. President, there is no question but that the State Society should endorse the advice of the committee on this important subject. In Essex County, the Secretary is very frequently asked by the members what to do. I always advise them to take the policy endorsed, studied, and recommended by the Advisory Committee, and I refer them to Dr. Beling for for any further details than those that were printed in the Journal. One of the questions that is prominent in their minds is with regard to the merits of the company and they are a little at sea also about what is in the contract. This is illustrated by the case of two men that were sued for conspiracy (I suppose that was it) and who were told by the representative of the Baltimore company. "No, I don't think that you

are covered because of the bodily injury and death caused thereby." But he returned to the company and this rider that Dr. Beling has reported was added. You heard Dr. Beling report that the committee favored a report that obviated such a gross error as that, and they thought it was in, but when it was presented to the Society, it was not. So it was referred back to the home office to put in a rider that covered a man against other things than bodily injury and death. I have discussed this matter with a number of doctors, and I have heard no objections to the plan that the Society have its own printed contract. An industrial company when it takes fire insurance has its own blanks; it may be insured in a dozen companies, but the same printed blank is used as the contract. That is important, they have found, in fire insurance because on settlement of damages, they have got to be worded alike to be sure that the payments are properly made, as between buildings and goods. I therefore offer a motion that this be referred back to the committee with the recommendation or suggestion that the State Society have its own contracts made up, printed and circulated and made the contract in any policy that Dr. Beling's committee suggests to us.

Dr. Hunter: There is a motion before the House now that precedes this motion. That that report be received and ordered printed in the Journal.

Dr. H. D. Corbusier: Mr. President, one of the troubles with the policy in its present form is the fact that it does not cover as much as other good companies. I have tried to take out this policy and have read a good deal of correspondence concerning it, but I never could find out whether my assistants were all covered or not. Theoretically they are, but practically, when you compare the working of this policy with other policies, they are not covered. I have corresponded for a year concerning it, because I really wanted to take it out, but without results.

President Eagleton: Gentlemen, this is a most important matter. As I have traveled over the State as your President, I have been asked questions about this group insurance. There has been a representative of some company going over the State who has been telling the men that the policy that is now offered does not give them protection. Now is the time to ventilate your questions, because the Chairman of your committee is here and will be able to answer them. I know there has been great dissat-

isfaction with the policy because of the active propaganda of another company.

Dr. N. L. Wilson: Mr. President, will Dr. Beling answer Dr. Corbusier's question as to whether or not it does cover assistants?

Dr. Beling: I would like to take this opportunity also to answer Dr. Pinneo's question, if you don't mind, Mr. President.

With regard to Dr. Corbusier's question, Mr. Wall went over these contracts and policies, and he says that the doctor is completely covered as to assistants, and in every way. He said that the contract should be entirely satisfactory to the members of the State Society, that is in the interest of the State Society. I am not a lawyer; I have to submit these things to the counsel of the State Society. He has given the matter careful consideration, and that is his answer. What Dr. Beling has to say is to be regarded entirely as a communication to the members of the State Society and is not to be used in any way by the public press or by those outside the membership of the State Society.

Dr. Beling: Dr. Pinneo states that the State Society should have its own printed contract. Dr. Pinneo brought this matter up during the course of the year, and I asked him if he would embody all these points that he had in mind and give them to me so that such a contract could be written. I presented these matters to Mr. Wall and Mr. Wall laughed at me. He said, "It is not necessary; you have a perfectly valid contract there. I don't see what further you can do with it." If Dr. Pinneo has any suggestions to offer, I will carry them to Mr. Wall. I want you to understand that I am the chairman of the committee; I am not the counsellor of the Society, and it is impossible for me to render legal opinions; I am transmitting the legal opinions of the counsel of the State Society.

Dr. Pinneo: Mr. President, any allusion I made was not in the nature of a criticism, it was an explanation of what men say. It casts no reflection upon the company or its contract.

As regards the matter of the printed contract, I do not even suggest that the contract shall be changed. If Mr. Wall advises the committee that the policy as printed in the F. & G. is the best policy, that is the thing to use, without the addition of a comma or a dash. But what we want is this printed contract in our offices. Then if the man chooses to go to any other company and say, "I will take your policy if you will put that in the contract," he has

the same contract as anybody else, and it will obviate a lot of this question. Therefore, I move that the State Society refer this back to the committee with the recommendation that they decide what contract the Society shall use and that they have it printed and circulated among the members. You see, it does not recommend what company they shall connect with; there is no suggestion on our part as to what the contract shall contain; it is simply a recommendation that the committee circularize the contract among the members so that every man will know what it is.

Dr. Hunter: Mr. Chairman, I still contend there is a motion before the House prior to Dr. Pinneo's.

President Eagleton: Dr. Hunter, I realize that is so, but I also think that this is the place for the men to learn about this thing and to ventilate their views. It is probably irregular to allow a man to talk on another motion when there is one before the House, but it has to do with the same subject and before we adopt Dr. Beling's report.

Dr. Hunter: My idea was to get my motion out of the way so as not to obstruct Dr. Pinneo's motion; because I think his is a very important one.

Dr. Fred J. Quigley: Mr. President, the only view that I have is with regard to the employment of the counsel of the State Society in all suits brought against the members of the State Society, and I rather think they are doing that now; at least, Dr. Beling tells me they are. There can be no question but that a lawyer who is defending this type of suit all the time is in a much better position to give defense to the physician sued than a lawyer who possibly for the first time is handling a malpractice suit. While some of the men may think it is easy to defend a malpractice suit, it seems to me it is a most difficult thing, and it is a highly specialized branch of law. The State Society has a counsellor who is eminent in his profession, and if the arrangement with the insurance company is not already hard and fast, I think it should be made so, so that the insurance company will employ at all times the counsel for the State Society in the defence of malpractice suits. The important thing, I want to reiterate, is that it is not fair to the members of this Society to pick out a lawyer in some community whose legal ability is not great, and who is absolutely unfamiliar with malpractice suits. I think the most important thing in connection with our suits at present is to see that the counsel for the State Society is always

employed by the casualty company that is writing our insurance.'

Dr. William Buermann: I would like to ask the question of Dr. Beling as to whether all the assistants are covered. He states that according to the counsel they are. I understand you have to designate who your assistant, substitute or aide is, and the names are requested. It is pretty hard to comply with that request because you may change substitutes. I understand in the questionnaire that you have to fill out when you make application for this group policy, you have to designate who your aide or assistant or substitute is. As I say, it is pretty hard to comply with that. A doctor may go away and get another substitute. He doesn't know who he is going to get. He wants protection in this instance because he may be sued for whoever he sends to a case in his stead, and it is a difficult matter for him to be able to give the name of the doctor he is going to use as a substitute. I understand that one of the other policies gives you protection, no matter who your substitute is.

Dr. Beling: The policy says very definitely that the doctor is protected, and any assistants he has. No names are mentioned in the policy. The policy covers that completely. The question may be asked, for the information of the company, but it is not embodied in the contract at all. The contract is very broad on that point. At this time, I would also suggest that this matter could be taken up by the committee again and presented to Mr. Wall, but I am quite certain that that was covered in the questionnaire.

President Eagleton: What was covered in the questionnaire?

Dr. Beling: In regard to the protection, that was covered completely. Yesterday, I had the opportunity of talking to Mr. Whiteside for over an hour. He is the counsel of the New York State Society and has had charge of medical defense for a number of years. And Mr. Whiteside is of the same opinion as Mr. Wall. He believes in group insurance. Mr. Whiteside made a number of suggestions. At present our method is that when a doctor is sued, he gives notice to the company and also to the Judicial Councillor of the district; then the company inquires of the Secretary of the State Society whether the man is in good standing. Then the matter is referred to the attorney. Mr. Whiteside suggested that that was a long route. The best way, he said, was for the lawyer of the State So-

ciety to get first notice; then he should decide whether the doctor is entitled to defense or not.

Dr. Pinneo brought up the matter of each individual having his policy and determining for himself whether he was defensible or not. That is a legal question, and it is a question that can only be determined by the lawyer. As it is at present, under the old Medical Defence Act, the Judicial Council first passes upon the question of whether the doctor is defensible or not; that is, whether it is a criminal matter or not, and then refers it to the counsel of the State Society. Mr. Whiteside believes that all this work should be concentrated in the hands of the attorney of the State Society, that he should get the first notice and immediately thereupon he should telephone and ascertain whether the man is in good standing. He will then make an investigation and issue his instructions to the local agents, and get the necessary information. He will have interviews with the doctor. He will get all the records of the case. If there was an autopsy, he will get the autopsy protocol. If there is a death certificate, he will get that. And when he has all this collected, he will be ready to receive the process that has been served upon the doctor who is being sued. Mr. Whiteside believes that there is a great strategic advantage to be gained by this promptness. In this way, I think our medical defence can be very much improved, not as to form, not as to policy, but as to method of handling. There was a question raised with regard to expert testimony, and what its value is. Mr. Whiteside says that in the State of New York they never pay an expert witness any money except travelling expenses. All the medical witnesses from the State Society are only too ready to give testimony. And, gentlemen, we ought to understand this: That when we ask men of the Medical Society to give testimony, we are not asking them to do anything criminal; we are not asking them to do anything wrong. We want the men to tell the truth, the whole truth, and nothing but the truth, and they take their oath to do that. In all the State Societies where group insurance has been carried on, it has been successful, and I feel we ought to get together here and work as a group.

President Eagleton: Gentlemen, it has been moved and seconded that this report be received and that it be published in the Journal. All those in favor signify by saying "aye," contrary-minded, "no." It is so ordered.

Dr. F. W. Pinneo: Mr. President, now I wish to call for my motion which has already been made, reminding you again that this is not a criticism of the committee's report or a recommendation even for the changing of the contract; it is not even a move to adopt my suggestion of the printed contract; it is simply a motion to refer to the committee with the recommendation that they take advantage of the committee's investigation of any company that they recommend, and that their recommendations as to any contract whatsoever still obtains; but that furthermore, those who are insured have a copy of the contract pasted in their policy, and that those who are not, have it as an advertising medium.

President Eagleton: It has been moved and seconded that this communication of Dr. Pinneo be referred to the committee. Is that what you want?

Dr. F. W. Pinneo: Referred to the committee with the recommendation for the adoption of a printed contract which shall be uniform in all the insurance policies.

President Eagleton: That would entirely alter the policy of the committee. Don't you think that that is a kind of broad thing to do, that is, to compel the committee to adopt another policy from that which they have already adopted?

Dr. Pinneo: Not at all. It is asking the committee to print the contract that they advise us to take. If supplementarily they advise us to take the F. & G., all right; this won't interfere with that. It doesn't put a premium upon the man who breaks away and takes another company's policy, if he wants to. It doesn't force him to take one certain policy. It gives him independence and still maintains the principles of the committee and furthers their work.

Dr. W. B. Johnson: Mr. Chairman, we don't want to force anybody to take this policy. We selected this policy because we thought it was the best policy obtainable for group insurance. We do want to recommend to every member of the Society that they become insured in this company. That is the way I feel about it.

Dr. Beling: May I answer that question, Mr. President.

That question is answered in the last paragraph of the second letter written to the committee by Mr. Wall. "Another question which was brought up was whether copies of the policy should be sent to every member of the group. That is a clerical question. As a practical matter, I should think it would meet all the requirements if the Secretary of the Society, with whom

the original policy is lodged, should be furnished by the insurance company with some extra copies, in order to comply with the requests of those members of the group who ask for copies."

I would like to ask Dr. Pinneo if he means to have this policy so written that it can be placed in this company, that company, or the other company. Is that your idea?

Dr. F. W. Pinneo: The idea is that a man would have that which constitutes the contract, without the amount of the premium, and without the names of the party of the first part. Therefore, in answer to your question, it may or may not be used with other companies, but at any rate it would leave in the contract what the committee recommends. I favor group insurance. I would say, in explanation of that, that, of course, group insurance is the thing.

Secretary Morrison: Mr. President, the farther this discussion goes, the more it seems to me that it is as clear as mud. To help to clarify the matter I would like to move, in compliance with the suggestion contained in Mr. Wall's letter, that we request this committee to have the U. S. Fidelity & Guaranty Company furnish them with slips containing the provisions of this contract for distribution among our members, with a view of increasing the insurance.

President Eagleton: All those in favor of Dr. Pinneo's motion signify by saying "aye," contrary-minded "no." It is lost.

We will now act on Dr. Morrison's motion. Will you repeat it, doctor?

Secretary Morrison: I move that we request the committee to secure from the U. S. Fidelity & Guaranty Company slips containing the provisions of their contract, for distribution among the entire membership of the Society, with a view to increasing the number of members who have availed themselves of this protection.

President Eagleton: Gentlemen, you have heard the motion, that these slips be requested. Is there and discussion?

Dr. E. J. Ill: I offer an amendment to that: that when that information is sent to each member of the Society, a copy of Mr. Wall's opinion be enclosed.

Secretary Morrison: I accept the amendment.

President Eagleton: It has been moved and seconded that the committee be requested to secure from the U. S. Fidelity & Guaranty Company slips containing the provisions of their contract, for distribution

among the entire membership of the Society, and that when these slips are sent out to the members, a copy of Mr. Wall's opinion be enclosed. Is there any discussion on the motion as amended? All those in favor of the motion as amended signify by saying "aye," contrary-minded "no." It is so ordered.

There is supposed to be in existence a Budget Committee of the Board of Trustees. By oversight, the Secretary and the Chairman of the Board of Trustees having left, there is only one member of the Board still here. Your Chair, therefore, takes the privilege of appointing to the Budget Committee the Second Vice-President, by virtue of his office, the Treasurer ex-officio, the Chairman of the Welfare Committee, and Dr. A. Haines Lippincott, to represent the Permanent Delegates on that Budget Committee.

Dr. Schauffler: I rise to a point of privilege: Unless I am very much mistaken, the committee is to be appointed by the incoming President and not by the outgoing President.

President Eagleton: That is right. I have presented to me a budget, to be acted on here. That budget was prepared by one member of the Board of Trustees and is now going to be submitted to you. I do not think that is the way to do business. As soon as the new President comes in, he can appoint whomever he pleases, but if there is going to be a report of a Budget Committee here for 1925, there should be some members who are present acting on it. Unless there is objection, your Chair will make these appointments. It has entirely to do with the transactions of this meeting.

Dr. B. S. Pollak: Before we adjourn, under the head of New Business, I would like to make a suggestion, and if it is your desire, I will put it in the form of a motion. The business of this organization is of a tremendous importance. We have held six sessions during our stay here. Each session has begun with a business session which has been more or less protracted, and the scientific program has, on account of it, suffered to a great extent. Many men came here to take part in the scientific discussions but were unable to stay because of the protracted business program. I think perhaps that is the business of the Committee on Arrangements. I don't know whether there are any constitutional provisions, but from the common sense point of view it seems to me it is the business of the Committee on Arrangements. I would there-

fore suggest, Mr. President, that the House of Delegates instruct this committee, or any committee that may be designated by you, sir, to arrange the program so that all the business of the organization shall take place on a certain specific day, or at a certain specific session, in future conventions, and that the scientific sessions shall not be interfered with by the business program. It is now half past eleven and we have come here to hear Dr. Danzis and others that are to present papers, and I am sure that the discussion of these papers which will be very interesting will have to be curtailed by reason of our business which, of course, must be considered.

President Eagleton: All this really should go to the Business Committee—that is true. I don't think it is necessary to make a motion on that.

Dr. B. S. Pollak: My point is this, Mr. President, that it should be the policy of the State Organization to adopt a program that will not permit the business part of it to interfere with the scientific part of it.

President Eagleton: I think you are right, sir.

President Eagleton: We will now open the general scientific session, and I will call on Dr. Max Danzis to present a paper on "*Local Anesthesia: Its Merits and Limitations.*"

Dr. Danzis presented this paper in abstract.

This paper and its discussions by Drs. J. F. Hagerty, C. M. Robbins, B. H. Greenfield, L. C. Lange, C. J. Larkey, C. Shields and M. Danzis will appear in the November Journal.

President Eagleton: Dr. Synnott's paper was passed over last night. I did not know it until after we had started this morning's session, but we will now have Dr. Philip Norman's paper on "Food Combinations" (as the doctor must go right back to New York), and after that I will call for Dr. Synnott's paper, if that is satisfactory to him.

Dr. N. Philip Norman presented his paper on

"*Food Combinations—An Original Scheme of Eating Based Upon the Newer Knowledge of Nutrition and Digestion.*"

This paper with its discussions by Drs. M. J. Synnott, C. H. Sexsmith and N. P. Newman will appear in the December Journal.

Dr. Synnott: Mr. President, the hour is so late that I will just hand my discussion into the Secretary for publication.

President Eagleton: Dr. Synnott said he would also hand in his paper on

"*The Modern Treatment of Diabetes.*"

This paper will be published in the November issue of the Journal.

SATURDAY AFTERNOON SESSION.

June 7, 1924.

The meeting convened at 2.40, Dr. Wells P. Eagleton, President of the Society, presiding.

We will listen to a paper by Dr. H. B. Corbusier of Plainfield on

"*The Success of Orthopaedic Practice, Dependent Upon the Proper Application of Physiotherapy.*"

Dr. Harold D. Corbusier of Plainfield, presented this paper in abstract, illustrating with slides.

This paper and its discussion by Drs. M. C. Avidan, W. J. Arlitz, J. N. Bassin and H. D. Corbusier, will appear in the December Journal.

President Eagleton: The next paper will be by Dr. Oswald S. Lowsley of New York, on

"*Preoperative and Postoperative Care of the Prostatic.*"

Dr. Lowsley presented his paper, illustrating with lantern slides and a motion picture demonstration.

This paper and its discussion will appear in the January, 1924, Journal.

President Eagleton: We will now call for the "Oration in Surgery" by Dr. Joseph C. Bloodgood of Baltimore. It is too bad that we can't discuss Dr. Lowsley's paper first, but Dr. Bloodgood must catch a train so we will hear from him now.

Dr. Joseph C. Bloodgood: Mr. President, I think this paper that preceded mine gives me a very excellent introduction to what I have to say. The last prostate case I saw—I am not doing prostatomy—was in Dr. Young's ward, the father of my technician, a colored man. There he was in this urological ward, where I believe they can do prostactomy as well as anywhere else in the world. He was dying. He had a permanent catheter in for drainage. He had the entire medical faculty at his hand to treat his uremia, and he died. He died twelve days after admission, and why did he die? Because he was an ignorant man and when his symptoms of enlarged prostate began he didn't know that he ought to see a doctor. Dr. Bloodgood's Oration will appear in the October Journal.

President Eagleton: I am sure that every-

body here feels like those of us who have had the pleasure of being under Dr. Bloodgood. We know what a wonderful teacher he is, and that the kind of teaching he gives is the kind that has endured since the world began; that he teaches practical medicine and practical surgery, and he is known all over the world for his wonderful work on scientific surgical pathology. But after all, when the specimens used to come down to his laboratory from the operating rooms, it was a delight to hear him analyze them, not knowing anything about the history, simply analyzing them by looking at the specimens. He didn't section them first of all; he took the specimens and examined them. And today there is probably nobody in the world who has the reputation that he has on surgical pathology. But fundamentally, it has always been clinical medicine. We thank you, Dr. Bloodgood, for what you have come and taught us.

Dr. Fred J. Quigley: Mr. President, I move a rising vote of thanks to Professor Bloodgood. The motion was unanimously carried.

President Eagleton: Dr. Bloodgood, you have the thanks of every member of the Society, I am sure.

Professor Bloodgood: I want to thank you gentlemen and to say, too, that I am glad I had a comparatively small audience because the temptation when you have a huge audience to say something that is not so is very great. In a small audience you aren't placed in that dilemma where you feel that you must use something besides facts. So I want to thank you also for the small audience.

President Eagleton: We will now have the report of the Budget Committee.

Secretary Morrison presented the report of the budget for 1925.

Budget for 1924-1925.

Allowance for:	
Committee on Publication.....	\$ 25.00
Committee on Welfare.....	40.00
Committee on Hospital	
Standardization	75.00
Committee on Credentials.....	150.00

Special Committees.....	300.00
Judicial Council.....	150.00
Delegates to A. M. A.....	250.00
Printing and Stationery.....	500.00
Legal Expenditures.....	1,500.00
Salaries and Expenses of Officers..	1,000.00
Annuity — Dr. Chandler.....	500.00
Secretary's Office.....	1,200.00
Treasurer's Office.....	75.00
Contingent Account.....	7,000.00

\$19,200.00

Expected Income:

Balance from 1924.....	\$7,000.00
Interest	700.00
Comm. on Arrangements.....	500.00

\$8,200.00

Balance to be raised..... \$11,000.00

Expected Membership, 1925..... 2,200

Per capita assessment of \$5.00. This assessment will provide the required sum, and we recommend that this amount be levied on the county societies.

President Eagleton: You have heard the reading of the budget report; what is your pleasure?

It was, upon motion, accepted and approved.

President Eagleton: Is there any other business to come before the Medical Society of New Jersey? If not, I wish to express my thanks to the Society for the uniform support and encouragement they have given me while I have been President, and I wish to say that I hope every president that comes after me will go out with the feeling of loyalty toward him that has been expressed toward me by every individual member. At the same time, I wish to offer my hearty congratulations and best wishes to the officers who will succeed me.

Dr. Lucius F. Donohoe: I want to take this occasion to thank the members of the Society for advancing me to the position of First Vice-President, and to ask for hearty support both for Dr. Mercer and his fellow officers in the carrying on of the good work that is being done by this Society.

President Eagleton: The One Hundred and Fifty-Eighth Annual Meeting of the Medical Society of New Jersey is now at an end.

Adjournment.

ADDENDA TO TRANSACTIONS.

PROPOSED CHANGES AND ADDITIONS TO BY-LAWS.

The changes in the Constitution were approved as they are recorded in the October, 1923, Journal, page 343, but final action thereon was postponed till the annual meeting in 1925.

The following are the By-Laws reported by the committee this year, with Dr. Morrison's suggested amendments, which will also be acted on next year. They have been prepared by Dr. Johnson, chairman of the committee, who has inserted the proposed amendments with the chapters and sections of the present-day By-Laws, in order that the amendments may be more intelligently understood.

(Alterations and Additions in large type; former sections in smaller type.)

BY-LAWS

of the

MEDICAL SOCIETY OF NEW JERSEY.

CHAPTER I.

Membership.

No changes in Section 1. The fellows and officers of, and the delegates (permanent and annual) to, The Medical Society of New Jersey are members, by act of incorporation; associate delegates, honorary members and guests by privilege of the constitution.

Sec. 2. February 1st in each year is hereby set as the date for closing the Official List. Five days before this date the Treasurer of each Component Society shall forward to the Recording Secretary and to the Treasurer of the Medical Society of New Jersey, a complete list of all the paid up members, with correct addresses. After this date no name shall be accepted for the Official List.

On the first day of February in each year, the Secretary of each Component Society shall send to the Recording Secretary a list containing the following information: the names of the officers, reporter and censors, the name of the member of the Nominating Committee, the names of Annual Delegates to the State Society, the names of deceased members during the preceeding year, the names of members who have resigned or moved out of the county during the preceeding year.

Upon the request of the Recording Secretary, the Secretary of each Component Society shall furnish a complete list of the names of all non-affiliated physicians resident in the county. The Official List as published each year shall be prima facie evidence of the right of all members to

register at the Annual Meeting and, unless otherwise ordered by the House of Delegates, shall form the basis of representation of the Component Societies.

(Sec. 2. The secretary of each component society shall furnish to the recording secretary of The Medical Society of New Jersey, at least one month before the annual meeting, a certified roster of its total enrolled membership; a list, as complete as possible, of all non-affiliating physicians in the county; a list of its officers, annual delegates and reporters, also a list of the members who have paid their assessments and are otherwise in good standing, which latter list shall be prima facie evidence of their right to register at the annual meeting, and shall form the basis of representation for the component society.)

No changes in Sections 3, 4, 5, 6 and 7.

No changes in Chapter 2; Chapter 3; Chapter 4; Chapter 5; Chapter 6; Chapter 7; Chapter 8.

CHAPTER IX.

Standing Committees.

Section 1. The standing committees shall be as follows:

(a) To be elected.

Finance and Budget.

Scientific Work.

Publication.

Hygiene and Sanitation.

(b) To be Appointed.

Credentials.

Honorary Membership.

Public Health Education.

Hospital Standardization.

Welfare.

Nominations.

Program and

Arrangements.

Business.

Committee on Finance and Budget.

Section 1. (a) The Committee on Finance and Budget shall consist of six members. They shall be elected for the term of five years, one member retiring each year. The members of this committee shall be elected by the Board of Trustees. It shall consist of one member of the Board of Trustees and five members chosen for election from among the Treasurers and Permanent Delegates of the Component Societies.

(b) Ten days before the Annual Meeting each officer of the Medical Society of New Jersey, and each chairman of the Standing Committee shall send to the chairman of the Committee on Finance and Budget an estimate for the amount of money required for his work during the next fiscal year. The Committee on Finance and Budget shall then proceed to consider and determine the amount of money to be raised and set the per capita assessment and shall report their recommendations to the House of Delegates at their first session. These estimates may then be approved, amended or rejected but final action shall not be taken before the

last session of the House of Delegates.

(c) No officer or committee may spend more money than the amount allowed without the approval of the Committee on Finance and Budget, which may apportion to such officer or committee on application, any unexpended balances of other items, if any, but this total amount expended must not exceed the total amount voted by the House of Delegates without the authority of the Board of Trustees.

Section number changed from old 5 to 2; old 6 to 3; and old 7 to 6.

Sections 2 and 3 replaced by section 5.

Committee on Arrangements.

(Sec. 2. The committee on arrangements shall consist of five members who shall be regularly nominated and elected, three of whom may be named from the component society of the county in which the next annual meeting is to be held. The president and recording secretary are ex-officio members of this committee.

It shall be the duty of this committee to provide suitable accommodations for the meeting places of the society, viz.: The general session, house of delegates, board of trustees, the various committees and exhibits. This committee shall have charge of all matters, and details pertaining to the general arrangements, and shall have power to enlarge by creating sub-committees as necessary or urgency may require.

The chairman shall report in writing an outline of the arrangements to the president for his approval, and subsequently to the chairman of the program committee for publication, and shall make announcements during the sessions as occasion requires.)

Program Committee.

Sec. 3. The program committee shall consist of the recording secretary as chairman, and two additional members, one of whom after the first year shall be elected annually for two years. It shall be the duty of this committee, after receiving the titles, together with brief abstracts of the papers to be read, with author's names attached, to prepare and issue a program announcing the order in which the papers, discussions and all matters of business are to be presented, which order shall be followed as nearly as practicable. All papers must be announced to the chairman of the committee thirty or more days before the annual meeting.)

Committee on Program & Arrangements.

Section 5. The Committee on Program and Arrangements shall consist of five members, three of whom shall be elected as follows: one for three years, one for two years, one for one year and thereafter one member to be elected every year to serve for the term of three years, who with the President of the Society and the Recording Secretary as members ex-officio shall constitute the committee. It shall be the duty of this committee to provide suitable accommodations for the meeting places of the Society, viz.: the general ses-

sion, House of Delegates, Board of Trustees, the various committees and exhibits. This committee shall have charge of all matters and details pertaining to the general arrangements, and shall have power to enlarge by creating sub-committees as necessity or urgency may require. It shall be the further duty of this committee, after receiving from the Committee on Scientific Work, the titles, together with brief author's names attached, to prepare and issue a program announcing the order in abstracts of the papers to be read, with which the papers, discussions and all matters of business are to be presented, which order shall be followed as nearly as practicable.

All papers must be announced to the Chairman of the Committee thirty or more days before the annual meeting. The Chairman of the Committee shall report in writing an outline of the arrangement to the President for his approval and shall subsequently have the program and announcements printed and mailed to each member of the Society.

Chapter X, old section 2 made 2a.

2b. That during the time the House of Delegates is in session the Business Committee act as a Committee on Resolutions, and that all resolutions be referred to them for recommendation before being acted on by the House of Delegates. That the Committee on Resolutions meet at the close of each session of the House of Delegates and report at the opening of the next session.

No change in section 3, 4, 5, and 6.

Chapter Eleven no changes.

Chapter Twelve, section 1—Change the words (on the first day of January) to "five days before the first day of February."

Chapter Thirteen no changes.

Chapter Fourteen no changes.

Chapter Fifteen—Section 9, replaced by Section 2, Chapter 1.

(Sec. 9. The secretary of each component society, in addition to that of its own members, is recommended also to keep a list of non-affiliating, registered physicians of the date of graduation and date of license to practice in this State, together with such other information as may be deemed important to the society. He shall furnish an official report containing such information upon blanks supplied him for the purpose, by the secretary of this society, when requested to do so. The roster kept should indicate any changes in the personnel of the profession by death, removal to or from the county, or by withdrawal from the society, and in making such a report he should endeavor to include an account of every physician who has lived, or is now living, in the county during the year.)

Chapter Sixteen no changes.

Chapter Seventeen no changes.

MEETINGS OF THE COUNTY SOCIETIES.

Atlantic County.—Meets Friday evenings monthly, except in June, July, August and September. Annual Meeting in November.

Bergen County.—Meets on 2nd Tuesday each month, except July and August. Annual Meeting in October.

Burlington County.—Meets 2nd Wednesday afternoon of January, April, June and October. Annual Meeting in October.

Camden County.—Meets 2nd Tuesday afternoon in February, May, October and December. Annual Meeting in October.

Cape May County.—Meets on 1st Tuesday in April and October. Annual Meeting in October.

Cumberland County.—Meets 1st Tuesday afternoon, 2 P. M., in January and October. Annual Meeting in October.

Essex County.—Meets 1st Tuesday in October as its Annual Meeting. Other meetings on call of President or Council, in the Academy of Medicine in the evening.

Gloucester County.—Meets 3rd Wednesday in March, May, September and November. Annual Meeting in November.*

Hudson County.—Meets 1st Tuesday evenings January to May, and October, November and December, at Jersey City Hospital. Annual Meeting in October.

Hunterdon County.—Meets on 4th Tuesday of April and October, the latter the Annual Meeting, at 10.30 A. M.

Mercer County.—Meets on 2nd Wednesday

of each month, except July, August and September, in the City Hall, Trenton, in the evening. The Annual Meeting is in December.

Middlesex County.—Meets on 3rd Wednesday afternoon of March, June, September and December. Annual Meeting in December.

Monmouth County.—Meets on 2nd Tuesday after the 2nd Monday in June and December. Annual Meeting in December.*

Morris County.—Meets on 2nd Tuesday evening in March, June, September and December. Annual Meeting in September.

Ocean County.—Meets in May and November as called by Secretary. Annual Meeting in November.*

Passaic County.—Meets on 2nd Thursday evening in each month, except June, July and August. Annual Meeting in May.

Salem County.—Meets on 2nd Wednesday in February, April, October and December at 2 P. M. Annual Meeting in October.

Somerset County.—Meets on 2nd Thursday afternoon in February, April, June, October and December. Annual Meeting in October.

Sussex County.—Annual Meeting on 3rd Tuesday in October. Other meetings on call of Secretary.*

Union County.—Meets 2nd Wednesday evening in January, April, July and October. Annual Meeting in October.

Warren County.—Annual Meeting on 2nd Tuesday morning in October. Other meetings at call of the President

*We have not had replies to our queries from these counties, therefore we give them as reported in the Annual Official List.

CONTENTS
of the
OFFICIAL TRANSACTIONS

	Page		Page
Address of President W. P. Eagleton.....	33	Palliative Treatment of Cancer of the Uterus and Breast, Dr. E. A. Ill....	23
Addresses of Welcome, Drs. Andrews and Nichols	1, 2	Post-Graduate Work for Rural Physicians, Dr. McAlister	26
A. M. A. on Lye Legislation.....	3	Pre-operative and Post-Operative Care of the Prostate, Dr. O. S. Lowsley ..	42
A. M. A. Report of Delegate Marvel....	14	Pulmonary Tuberculosis Treated by Artificial Pneumothorax, Dr. Fine...	33
American Psychiatric Ass'n, Dr. Williams	13	Roentgen-Ray Therapy in Hemorrhagic Metropathies and Uterine Myomata, Dr. Roemer	23
Annual Meeting Place for 1925 Chosen..	32	Success of Orthopedic Practice; Application of Physiotherapy in, Dr. Corbusier	42
Board of Trustees Reports, Dr. English..	8, 34	Permanent Delegates, Nominated and Elected	3
Budget Committee, Discussion, Report..	41, 43	Report of Recording Secretary Morrison	5
By-Laws Amendments, Dr. Morrison....	10	Report of Corresponding Secretary.....	33
Enforcing Medical Practice Act, Mr. Whiteside	6, 8, 33	Report of Treasurer Marsh	11
Full Time Assistant for Secretary.....	6, 8	Reports of—	
Gorgas Memorial Resolution	2	Auditing Committee	14
Industrial Medicine and Surgery Committee Appointed	24	Arrangements and Program	3
Medical Society of New York; Report, Dr. English	15	Business Committee	27
History of South Jersey, Secretary's Communication on	2	Constitution and By-Laws Revision..	10, 44
Nominating Committee, Appointed, 26; Report	30	Credentials Committee	28, 33
Oration in Medicine, Dr. E. J. Beardsley	29	Honorary Membership	11
Oration in Surgery, Dr. J. C. Bloodgood..	42	Hospital Standardization	17
Original Articles—		Judicial Council and Councilors	18
Enforcing Medical Practice Act, G. W. Whiteside	33	Medical Defense and Indemnity Insurance	37
Food Combinations, Dr. Norman	42	Prize Essay	16
Health Problems in Education, Dr. Haight	24	Publication Committee	4
Local Anesthesia; Merits and Limitations, Dr. Danzis	42	Scientific Work Committee	4
Manual Artificial Respiration for Resuscitation, Dr. Pinneo	29	Standardization of Disability in Eye Injuries	16
Modern Treatment of Diabetes, Dr. Synnott	42	State Board of Medical Examiners....	34
		University Extension; Post-Graduate...	26
		Welfare Committee	19

Journal of The Medical Society of New Jersey

Published on
the First Day of Every Month



Under the Direction
of the Committee on Publication

Vol. XXI, No. 10 ORANGE, N. J., OCTOBER, 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

ORATION IN SURGERY.

THE CONTROL OF CANCER A PROBLEM OF EDUCATION.

Delivered at the 158th Annual Meeting of the
Medical Society of New Jersey, at Atlantic
City, N. J., June 7th, 1924.

By **Joseph Colt Bloodgood, M.D.,**
Baltimore, Md.

After thirty-two years of continuous study of more than forty thousand records in the Surgical Pathological Laboratory of the Johns Hopkins Hospital and from an extensive reading of the literature and personal discussions with my colleagues, I am forced to the conclusion that a very large number of deaths from cancer are due to ignorance.

Essential Facts.—Apparently it is less difficult to assemble the facts than to put the message in language which will be read, remembered and acted upon.

The things that all of us must remember in our endeavor to prevent, or to recognize cancer early, may be briefly summarized as follows:

We are all, with few exceptions, warned in time, but we all need instruction, how to act in time, and we need something else. We know we are warned, we know we should act, but what is it that will make us act in time? There seems no question that a very large number, if instructed, will act in time. How to influence the remainder, we as yet do not know. Some of my colleagues are of the opinion that this group better be allowed to die. I cannot agree with them. It seems to me that the medical profession must do more than instruct. They must influence their patients in such a way that they will follow their instructions. The science of medicine is essential to know what to instruct, but it is the art

in medicine which makes it possible for the members of the medical profession to so influence their patients that they will follow instructions.

Many wise men with whom I have conferred are of the opinion that the science of medicine has advanced further than the art of medicine. The difficulty today is not the disease, but the individual, the seat of the disease. To educate them to come early, and when they do, to get them to follow the correct advice, is the more difficult part of our daily work and is the great art of medicine in the control of disease.

The Teaching Function of the Doctor.—If you have late cancer in your community and in your hospitals, it is largely the fault of the medical profession. I have never heard an argument against this statement. The majority of the medical profession recognize the truth, but neither as individuals, nor as groups, do they act as it is possible for them to do.

Members of the medical, the dental, the nursing professions are the logical teachers not only of their patients, but of their communities. There must be not only individual instruction, but the various societies and hospital groups must do their part. The instruction can be given through personal contact in conversation, by lectures, through the public press, and by pamphlets. It must be continuous and based upon facts. Any individual or society or hospital can obtain the facts and latest information from the Central Office of the American Society for the Control of Cancer at 370 Seventh Avenue, New York City.

What Has Been the Effect of the Educational Efforts.—The records in the laboratory have been divided into decades, the first from 1890 to 1900, and the fourth beginning with 1920. It is very easy to figure out the per cent. of inoperable cases.

This has decreased steadily and is most marked after 1915. As to the per cent. of permanent five-year cures we can consider only cases up to 1919. The improvement in operability in all regions is greater than the improvement in the per cent. of permanent five-year cures. We will soon be able to ascertain what has happened since 1919. I feel quite confident that in the breast, lip, tongue, skin, the per cent. of permanent cures will show a great increase since 1919, but there is no evidence of this improvement in the gall bladder, stomach, colon, and rectum.

This study of operability and curability is a very interesting one. In almost every locality a certain per cent. of cancer may be very acute, and the local lesion becomes inoperable within a relatively short time. In this group metastasis also takes place early. Up to 1915 most of these patients with acute carcinoma were seen in the inoperable stage. In fact, many died without being observed or recorded in any clinic. The educational campaign has brought many of these patients under observation when the local lesion was apparently just as operable as in the less acute types, and there was no evidence of metastasis. This group, then, for the first time, was subjected to operation, but the disease was really disseminated, and all of the patients promptly showed recurrence and died from metastasis.

Bringing this group of acute carcinoma from the column of inoperability to that of operability temporarily decreased the per cent. of five-year cures.

The more interesting and more startling group is the increasing number of local lesions which are not cancer and are either distinctly benign, or what may be looked upon as precancerous lesions.

Lesions of the breast, lip, tongue, skin, stomach, colon, rectum, etc., may be divided first into four decades and then subdivided into *benign, no operation; benign, operation; operable, malignant, without glandular metastasis; operable, malignant, with glandular metastasis; inoperable locally or because of definite evidence of internal metastasis.*

There is no question of a marked change in every group, most marked in external cancer and least marked in internal cancer. The greatest contrast is between the first decade (up to 1900) and the last decade since 1920. The most marked improvement in five-year cures is from 1915 to 1919.

It is important to record that my records are from all the patients in Johns Hopkins and St. Agnes hospitals and other hospitals in Baltimore and in Maryland, but in recent years there has been an increasing number of cases referred from hospitals outside of Maryland, and, in addition, more than one-half, perhaps two-thirds of the patients live outside of Maryland. For this reason we can see the effect of the educational campaign in many other States besides Maryland; so that when patients come early, it cannot be credited to the work of the Maryland Cancer Committee, or the medical and nursing professions of Maryland.

In addition to this, in all my own recent histories, perhaps for ten years we have asked the patients and recorded the answer of when they first sought the advice of a doctor, and why.

When the local condition had become inoperable or was in the late stages of cancer, in the vast majority of cases the patients and their families have all been ignorant of the dangers of delay and have neither heard or read of the true facts in regard to cancer. Since 1920 these inoperable and late cases give evidence not only of the ignorance of the patients and their families, but in the locality from which they come. We should try to educate these areas of ignorance when they are thus brought into the limelight.

On the other hand, when the local lesion is in the early malignant or the benign stage, we practically never fail to reveal that the patient or family have gotten somewhere correct information in regard to cancer.

My own evidence, therefore, convinces me of the great beneficial effect of the educational efforts of the American Society for the Control of Cancer through all its branches and of the medical societies, county, State and national, and of the individual efforts of single members of the nursing, dental and medical professions. There is also every evidence that the people themselves are passing on the correct information in regard to cancer.

Who Delays Now?—Up to 1900 my records show that the greatest delay was on the part of the patient, the next on the part of the family physician, and, third, on part of the surgeon, or specialist called in consultation.

Delay on the part of members of the medical profession has practically been eliminated.

Difficulties of Diagnosis.—There is nothing new in these statements. I have emphasized it in most of my contributions; it is mentioned in the literature, especially recent, and every doctor knows that if patients seek his advice at once, he is to encounter great difficulties in diagnosis. In the past five years the number of early cases increased so rapidly and lesions are coming under observation so much earlier, that no text books can keep pace with the diagnostic problems, and even those clinics and individuals who are most familiar with the situation and have the largest material find it difficult to study their cases up to date and publish the results of their investigations.

Personally, I have been observing and recording and restudying especially lesions of the breast and bone and oral cavity and jaw and other localities and sites, and I find it impossible, in spite of many publications to keep up with the new material, the presentation of local lesions in a stage rarely seen before.

It would appear as if there must be some method of organizing our efforts so that the whole profession can be kept informed on the newer clinical pictures and methods of diagnosis and methods of attack of the various lesions in their earlier and earliest stages.

Breast.—Up to 1900 almost fifty per cent. of the women who went to the surgical clinic of Johns Hopkins Hospital with a cancerous lump in the breast were in the hopeless, inoperable stage, and the duration of those lumps with rare exceptions was more than one year, often two years and longer. This has gradually decreased. Since 1920 less than five per cent. are in this hopeless group.

Of those operated upon during the first ten years of the clinic up to 1900, in very few were the glands not involved, and the per cent. of five-year cures ranged between twenty and twenty-five per cent., but practically all these patients who have lived more than five years, with few exceptions have died of cancer. That is, they were in the operable stage, but not in the curable period. Halsted's operation must be looked upon as one of the great surgical triumphs of that decade. There has been no improvement in the technique of Halsted's dissection *en bloc*. The next great triumph has been the educational effort which has brought these women to operation at an earlier period.

It is very important to remember that

the per cent. of cures of cancer of the breast has been pretty definite in relation to metastasis to the glands. If the glands are not involved, at least seventy per cent. remain free from recurrence five years or more. If the basal glands only are involved, five-year cures fall to twenty-five per cent. With extension to the mid glands to twenty per cent. with involvement of the glands in the apex a bare ten per cent. are apparently free from signs of recurrence after five years, and all of them ultimately succumb to cancer metastasis.

I feel confident from recent studies that the cases operated on since 1920 are going to show a great improvement. There is one thing we know already—the number of cases without glandular involvement who have at least seventy per cent. chances of a five-year cure are now in the majority, while previous to 1900 such observation was unique or questionable.

I am beginning to feel that perhaps the probability of a cure in cancer of the breast without metastasis to the glands may show an increase, but at the present time this is the best that can be offered.

The most striking observation is the number of women who come under observation in my clinic in which, after careful observation, operation is not indicated. I reported this in 1922 under the title: "Benign Conditions of the Breast, in Which Operation is not indicated."

Up to 1900 there are only two histories of women who came to the clinic who were not operated upon, except the inoperable group of cancer. This was less than one per cent. By 1920 it had increased to fifty per cent. in my clinic. It has now increased to sixty per cent. During my visits to various clinics throughout this country I am seeing more and more of this group.

There are women who complain of pain, with and without a lump, women who think they have a lump, but have no pain; then there is the discharge from the nipple; the disappearing tumor; the lump in the axilla; the skin lump do to mosquito and other bites. When these women are carefully examined, we find lumpy breasts, shotty breasts, dilated ducts beneath the nipple, and multiple definite tumor in one or both breasts. The palpating finger is the most important for diagnosis. We have no instrument of precision to help us here. In practically all cases with the exception of pain and discharge of blood from the nipple, we must depend upon palpation and palpation only. In Paget's disease of the

nipple this is materially aided by inspection.

I have discussed this point again and again in my contributions. I feel quite encouraged that the profession throughout the country is beginning to realize the importance of giving these women who seek their advice early a most careful examination.

Breast—Disappearing Tumor. — I am quite confident that the majority of surgeons have been aware of the disappearing tumor, especially since 1900. It is not discussed by Billroth, Velpeau or Paget. It is interesting to record that one of the first women admitted to the clinic of Dr. Halsted in Johns Hopkins Hospital with a lump in the breast refused to be operated upon; there was nothing to be felt in the breast but a lump; the history however diagnosed it cancer. Five years later when I began to write these patients this patient reported that the tumor had disappeared a few weeks after she had left the hospital, and she lived more than twenty-five years dying of old age. I remember distinctly in 1890 at a clinic at the Blockly Hospital in Philadelphia that a distinguished internist described to us a patient with a lump in the breast which the great surgeon Agnew urged operation for, and which he, the internist, had diagnosed gumma and cured with iodide of potassium, at least the tumor disappeared.

Of all the clinics on breast lesions which I attended as a student and of all the information I must have received in lectures, I remember only this, the tumor which disappeared under iodid of potassium and the statement of Dr. Agnew that he had never cured a cancer of the breast by operation. It is important to record here that Agnew removed the breast only.

Chronic cystic mastitis in its various clinical and pathological types is largely responsible for the disappearing tumor. The next most common disappearing tumor is the caked breast and even mastitis during lactation, the next galactocele. Recently I have seen a number of fairly definite nodules always multiple which follow contusion of the breast. When women waited these tumors were very rarely seen, only the small number which persisted. As women come earlier my figures show that these groups are increasing rapidly.

Male Breast.—There was a patient in my office today—a man, aged forty, with enlargement of the right breast; it has been present four weeks. He has seen a physician within a few days and in these four weeks has been examined by at least six

members of the profession who have had considerable experience with breast lesions, but as one must see at least one hundred women before observing one man with trouble in the breast, it is readily seen that experience with lesions of the male breast comes very gradually. About two-thirds favored a benign lesion and one-third a malignant one.

Fortunately, the material which had accumulated in the laboratory for thirty years was restudied again this summer, as my colleague Dr. Wainwright of Scranton was anxious to make an investigation on lesions of the male breast. The most striking feature is that up to the present time there is not a single recorded five-year cure of cancer in the male breast. In a few cases the man had come under observation with a cancer in the early stage, but unfortunately the tumor only was removed, and the opportunity for a possible cure lost. All the other records show a distinctly late stage both in regard to time and the definite signs of malignancy. Perhaps the larger group of male lesions are not cancer, but what is known in the literature as diffuse hypertrophy. Many of these cases have been diagnosed malignant and subjected to complete operation. In all the breast at least had been removed; a few of these have been bilateral.

As I have studied this material again and again I have never been able to convince myself that cancer ever began in a diffuse hypertrophy of the male breast or had any relation to it, and I get the impression that the so-called diffuse hypertrophy of the male breast corresponds to chronic cystic mastitis in the female, and that if left alone it would disappear, but nevertheless I have never felt justified, after a diagnosis of benign diffuse hypertrophy, to abstain from removal of the breast. Today, therefore, we had a case in point. We can see that the right breast is larger; we can feel it almost has a distinct edge. There seems to be a definite etiological factor. This patient who had given up tennis for many years and golf for some months, suddenly took up tennis and played very actively with his right arm. After a few days, while taking a shower bath he felt and saw his right breast to be larger. There was no pain. He thinks that it is getting smaller. Now, if one could be certain from this history and the palpation that this is a benign condition and a diffuse hypertrophy and that it has no relation to cancer, one would be perfectly justified to delay, because, if

it is not cancer and there is no more danger of cancer than in the normal breast, there is no danger in delay, and if it disappears, the patient will be saved an operative intervention. This case, then, is a good example of the increasing diagnostic dilemmas that we are encountering when patients seek advice very early. If this man had waited six months and the lesion were cancer, there would have been no difficulty in diagnosis and little probability of a cure, while if it were diffuse hypertrophy, we could feel quite sure that the chances of its disappearing had passed and that the breast should be removed.

What we have said here in regard to the breast, is true with regard to lesions in every other locality.

This man has just been operated upon and the frozen sections show the lesion to be benign diffuse hypertrophy.

The following references are given because all the points discussed in this paper are more fully described and in many illustrations have been produced:

Benign Lesions of the Female Breast for Which Operation Is Not Indicated. Jour. A. M. A., 78:859, March, 1922.

The Pathology of Chronic Cystic Mastitis of the Female Breast, Archives of Surgery, 3:445, Nov., 1921. (91 illus.)

Diagnosis of Early Breast Tumors, Based on Their Clinical Picture or Their Gross and Microscopic Picture at the Exploratory Incision, Boston Medical and Surgical Jour., 187:243, Aug. 17, 1922. (20 illus.)

The Clinical Picture of the Diffuse Type of Chronic Cystic Mastitis (The "Shotty" Breast) Southern Medical Jour., 15:907, Nov. 1922. (1 illus.)

The Clinical Picture of Dilated Ducts Beneath the Nipple Frequently to be Palpated as a Doughy Worm-like Mass—the Varicocele Tumors of the Breast, Surg., Gyn. & Obs., 36:486, Apr., 1923. (4 illus.)

The Diagnosis of Early Breast Tumors, Jour. A. M. A., 81:875, Sept. 15, 1923.

The Medical Aspects of Disease of the Breast. (What Every Physician Should Know About the Breast). Medical Insurance Combining Practical Medicine and Surgery, 39:304, Dec., 1923. (7 illus.)

Benign Tumors of the Breast. Encapsulated Adenoma, Annals of Surgery, Feb., 1924. (27 illus.)

Paget's Disease of the Female Nipple, Archives of Surgery, 8:461, Mar., 1924. (39 illus.)

One Way to Prevent Cancer. Prompt Attention to a Lump in the Breast, Hygeia, 2:434, July, 1924.

*In my address before the New Jersey State Medical Society I used lantern slides illustrating actual cases and covered not only the breast, but the bone and the oral cavity, the jaw, skin, lip and some other regions and types. It would be impossible to reproduce these illustrations here, and it seems best in

the written article to use the breast as illustrating the facts discussed in the beginning of the paper.

MANUAL ARTIFICIAL RESPIRATION FOR RESUSCITATION: ITS INDISPENSABLE IMPORTANCE.*

By Frank W. Pinneo, M.D.,
Newark, N. J.

History.—Familiar as we are with the physiology of respiration, it is not easy to believe how slowly this knowledge came. Only the muscular movements were known and the explanation of vital functions, like breathing and heart action, as due to "animal spirits" which passed down nerve tubules from the brain, prevailed even in the minds of the great medical observers down to the time of Harvey; and even his wonderful discovery of the true circulation of the blood (1628), fundamental in physiology, awoke no new knowledge of the physics of respiration, the function of which was thought to be the cooling of the blood by the entrance of air; and progress in this could come only with better knowledge of the *Chemistry* of respiration. The world waited another half century for this knowledge; and Mayow, a young doctor, of Oxford, was the discoverer who opened the door (1673). The key which he used was a comparison of combustion of fuel, or gunpowder, in air with that of respiration. This discovery of combustion in physiology gave for the first time an adequate explanation of increased breathing under muscular work. He had practically discovered oxygen, without so naming it, a century before Priestley, 1774. Interesting for our subject is another significant observation made at Mayow's time by Hooke, Secretary of the Royal Society, that an animal with chest opened and lungs collapsed could be revived by artificial respiration and even kept alive if the lungs be punctured and a stream of air be continuously passed through them, even though they do not move. Strangely, these discoveries at Oxford slumbered long before yielding the results familiar to us now, such as Meltzer's epochal discovery of intra-tracheal insufflation in our day, over two hundred years later.

Incidentally, may be mentioned a curious

*Read at the 158th Annual Meeting of the Medical Society of New Jersey, Atlantic City, June 6, 1924.

bit of history. The Japanese for centuries have known what is called the Katsu Method of Resuscitation, which is an adroit, sudden, manipulation of nerve trunks in the neck affecting what is described as the "nerves of the pectoral arch," presumably the brachial plexus, and the sympathetic ganglia with their cranial nerve relations. Significant is the effect upon the pneumogastric and auditory nerves. An American, Captain McLagen, in defeating at Jiu-Jitsu (1907) the Japanese Champion of the world, was taught confidentially the secret and claims to have applied it with success on the apparently dead.

Physiology.—Of the very many interesting facts—chemical and physical—in the physiology of respiration a few may be here recalled. Inhalation is a co-ordinated muscular contraction induced by nerve impulse from a definite area in the floor of the Fourth Ventricle in the Medulla Oblongata, hence called the respiratory center. The most instant death we know is by the destruction of this tissue. Exhalation is muscular relaxation, although we cannot say there is no nerve impulse for this also. Experiments demonstrate a wonderful vitality in this "center" which, cut off from all nerve channels, will live on, discharging normal rhythmic impulses, if only supplied with arterial blood. This is an encouragement to artificial respiration because, if oxygen be supplied to the alveoli in the lung before the heart stops, blood will reach the respiratory center and life will be maintained till recovery of normal functions. Many kinds of stimuli affect breathing; chemical, in the constituents of the air, breathed, as acapnea or lack of CO_2 ; blood conditions, as anoxaemia or lack of oxygen in the blood; acidosis or lowered alkali reserve; voluntary control to a very great degree, so that one may hold breath till blue and dizzy, even unconscious, but never to death. Air in the lungs may be tidal (ordinarily used) or supplemental (available for use) or residual (never emptied but helping diffusion in the alveoli). The amount of oxygen in the air has little effect on breathing, a diminution from the normal content of the atmosphere (21%), to below 14% being necessary to increase the breathing; and much lower percentages are tolerated. Increased percentage of the oxygen in the air breathed produces no increased oxidation in the tissues. On the other hand the influence of CO_2 is very great, for raising the normal 0.03% in atmospheric air to 3% produces increased

breathing, and 6% panting and exhaustion. 10% is the limit of endurance and raising the percentage of oxygen gives no relief. Increased breathing therefore is due to increased production in the tissues of CO_2 and not at all to the reduction of oxygen (except extreme reduction to as low as 2%.) An important fact, pointed out by Yandell Henderson, is the influence of anesthetics on the sensitiveness of the respiratory center to the CO_2 stimulus. Ether increases it. Chloroform, morphine, chloral, diminish it, commonly to such extent that the arterial blood becomes markedly blue without increasing the breathing.

Artificial Respiration.—Artificial respiration had its place in the history of medicine before anything of the chemistry of breathing was understood or even its physics. But imitation of the mechanical movements, nevertheless, provided efficient means for resuscitation. Elisha, the prophet, 850 years B. C., is described as applying a "direct" method, mouth to mouth, on a boy brought in from the harvest field. In 1767 an association was formed in Amsterdam, Holland, and in 1774 (the date of Priestley's discovery of oxygen) their proceedings were translated for use by a Royal Humane Society in England, Marshall-Hall brought out his method, rolling the patient from side to prone position, in 1857; Sylvester improved this with his supine position and using the arms to alternately expand and depress the chest, in 1863. This is excellent and has been until recently widely used. Howard's method, 1869, turned the patient quickly from prone to supine. Schafer, of Edinburgh, in 1902, under the Royal Medical Society, brought out the "prone pressure" method and showed by it a pulmonary ventilation three times greater than any other. In 1911 the National Electric Light Association, the American Medical Association, and the American Institute of Engineers formed a Resuscitation Commission for research and universal adoption of the best method. The Commission in 1918, with S. J. Meltzer as chairman (he having discovered intra-tracheal respiration and then suggested it for anesthesia) again went over the whole ground and came to the decision by which we are now guided. The American Gas Association in 1922 asked for investigation of gas poisoning and the Commission on Resuscitation from Carbon Monoxide Poisoning was formed with Dr. C. K. Drinker, chairman, also Drs. Cannon, Edsall, Haggard, L. J. Henderson, Yandell

Henderson, Lewis, Peabody, and Sayers. They made important researches and a far-reaching report. Dr. Sayers is with us today to discuss our subject. There are four prevailing and very frequent conditions, Gas Poisoning, Electric Shock, Drowning and Anesthesia Collapse, needing artificial respiration. Its importance has naturally aroused interest not only in our profession but in the public at large and to supply this interest machines have arisen with the result that resuscitation has fallen into the unfortunate place of neglect of an always ready means—manual method—while awaiting an apparatus. But more important than this delay are the faults of mechanical apparatuses when they do arrive for reasons which prompted the Accident Prevention Committee of the combined industries to advise all the member companies to scrap all mechanical devices and teach rescue crews manual artificial respiration. As a result now all the companies in the American Gas Association and the National Electric Light Association have adopted the Schafer prone pressure method and ordered all mechanical appliances into the discard.

Naturally mechanical apparatuses are built upon the principle of external positive pressure alternating with negative pressure or suction from the chest cavity. The lung-motor and pulmotor are typical. Even any clever device whereby the volume of tidal air is adjusted to the assumed capacity of the chest, big or little, or any provision for a spill-way from one channel to the other, to obviate excessive action, cannot controvert the criticism that the whole action is contrary to physiology and cannot fully supplant nature's method of automatic chest expansion and contraction. The Resuscitation Commission in its researches studied among the many questions involved (1) The effects of positive pressure in the alveoli upon pulmonary arterial pressure and increased load on the right heart; (2) The effect of positive pressure ventilation on distributing infective material through the lungs; (3) The ventilating efficiency of the apparatuses; (4) Leaks of face-piece, even when expertly applied, especially on inhalation, producing gradual rarefaction of air in the lungs; (5) Increase in numbers of pneumonia which were found to be 5.9% of all cases gassed, this including no doubtful or slight cases but only those showing clinical and physical signs. 28% of serious cases had increased fluid in the chest; (6) Other factors, such as heart

volume, respiration, systemic blood pressure and changes in the pulmonary circulation.

The impression given a reader of the newspaper by the frequent accounts of lung motor or pulmotor used in gas-poisoning cases, is that they are benefited—whereas statistics show that only 20 to 30% of all cases recorded were saved or helped. Often the patient is breathing though unconscious and the danger is not asphyxiation but the tissue damage following. The arrival of the apparatus is too frequently beyond the limit of the time in which respiration must be resumed or else the case has automatically recovered and needs no artificial respiration—He may need elimination of the gas and relief from the complicating oedema.

Prone Pressure Method.—Of all the methods for artificial respiration the Prone Pressure Method of Prof. Schafer is now chosen for several reasons. The position is prone, therefore facilitating extraction of foreign material from the throat, such as water, sea-weed, or sand, and the tongue falls forward; it is the least laborious to the operator; the risk of damage by over exertion is small, the pressure being upon abdomen rather than ribs; it secures greatest air exchange in each respiration and in a minute this amounts to a considerable benefit. In the following table five methods are contrasted showing the air exchange for prone pressure 520 C. C., where natural tidal air was 450 C. C. and the total exchange per minute 6,760, where the natural was 5,850.

METHODS	Respirations per min.	Air exchange each resp.	Exchange per min.
Natural	13	450c.c.	5850c.c.
Silvester	13	175	2280
Howard	13	310	4030
Marshall-Hall	13	254	3300
Prone Pressure (Schafer)	13	520	6760

Electric Shock.—The greatly increasing frequency of electric accidents makes first aid treatment for them extremely important. Every minute is valuable. The action of electricity is upon the nerve trunks, causing while the current passes a block to any nerve impulse, but causing no permanent damage (unless the current is of considerable strength). This explains the phenomena of shock with recovery fol-

lowing if the application has not been so long as to cause death and if during the time the nerve cells, in this case the respiratory center in the medulla, have been steadily supplied with arterial blood. Nerve cells must have fresh blood incessantly, hence the treatment for electric shock is prompt artificial respiration to provide the nerve cells with fresh blood till the conductivity of nerve paths returns. Efficiently applied it works, if the heart is still pumping. Cases in which the current passes directly through the heart are fatal from ventricular fibrillation, which instantly destroys the rhythmic pumping action. The time during which nerve centers can be completely deprived of blood and survive has been determined and varies from 8 minutes in the cerebrum to 20 or 30 in the medulla, and 45 to 60 in the spinal cord. It will be seen at once that a manual method is indispensable and mechanical apparatus a poor substitute even if it were built upon correct physiological principles. The danger is asphyxiation, not tissue damage to follow.

Gas Poisoning.—In gas, (carbon monoxide) poisoning we are confronted by a complicated condition of a rather prolonged poisoning which has damaged the red blood cells and, further, the brain tissue for, as above stated, the cells of the cerebrum can survive lack of oxygen only half as long as those of the medulla and one sixth those of the spinal cord. The depression continues long after resumption of breathing hence not merely due to the asphyxia but to the ensuing oedema of brain and there is very little elimination of the poison which is firmly fixed in the red cells. Hence the coma and death long after breathing has resumed. Oxygen is not a help being feebly inhaled. Former treatment has been bleeding, to remove the damaged blood cells but we now know this was wrong, robbing the body of needed blood, and furthermore, the elimination of the monoxide from the blood is not as hopeless as thought. This change has come largely through such researches as Henderson and Haggard's showing the value of CO₂ as a respiratory stimulant 8% added to the air inhaled producing a 200 to 300% increase in volume of respiration. Their inhalator for this purpose is admirably designed and should be available for all gas cases. Do not let any one get an idea that this is any machine for artificial respiration. It is no substitute for a manual method. It for resuscitation from gas-

poisoning by administering CO₂ for a stimulant with oxygen for breathing. The thought that it might for like reasons aid recovery from anesthesia has prompted us at the Newark City Hospital to begin a series of cases—with control—of administration of CO₂ with O₂ following the anesthetic.

Drowning.—Here we are dealing with an emergency due to cessation of respiration while the heart is still beating and the blood and its circulation are normal. The pathology is usually not that of a waterlogged lung, but rather of obstruction in the upper air passages and trachea, seldom deeper than the major bronchi. The limit of time after cessation of all breathing for recovery is 10 minutes. Here then is a typical condition demanding prompt artificial respiration like electric-shock and different from gas-poisoning. Life-saving depends upon the respiration. A universal knowledge of the simplicity of a manual method would cultivate increased efficiency and afford resources for unfortunate victims, which would doubtless save many. A safe rule for the length of time to maintain artificial respiration is expressed in the advice "consider as death nothing less than cooling of the body or rigor mortis."

Anesthesia Collapse.—This is a complex problem involving perhaps factors in pathology in other organs than respiratory—shock from surgery or hemorrhage or narcotic. In any case without waiting to make an analytical diagnosis, a safe rule is to: (1) immediately remove the anesthetic and be perfectly sure the air-way is free; (2) apply manual artificial respiration if the breathing does not resume in a few seconds. Cases are of two groups: (1) cardiac due almost always to lesions already known—these mostly under chloroform; (2) respiratory. A small group of the latter are due to central causes. The following cases recorded by Cushing are typical. Cerebellar tumor: Patient in prone position, breathing ceased,—manual artificial respiration applied and maintained for 48 minutes when tapping of cerebellar cyst was followed by resumption of natural breathing and patient recovered and is reported still well. Another case of cerebellar tumor—patient in prone position, incision followed by profuse bleeding which revealed a lake of blood from a hole in the bone, breathing stopped, blood became black, respiration not resumed, Schafer artificial respiration applied for 45 minutes, heart action maintained, operation continued till herniated edges of cerebellum

were liberated, relieving the pressure; spontaneous breathing then resumed, pulse fell from 120 to 80—cerebellar cyst removed one month later, patient well seven years afterward. The Resuscitation Commission endorses with all emphasis possible this method for such emergencies. I have frequently observed in anesthetizing cerebellar cases for Dr. Eagleton, a critical time when, the cerebellum being exposed, manipulations caused pressure on the medulla and respiration ceased, perhaps only momentarily. The Schafer method affords an efficient means for artificial respiration, while the operation may continue.

Summary.—1. Manual artificial respiration is indispensable and cannot be replaced by any apparatus or any drug, nor by oxygen.

2. All machines for artificial respiration should be discarded as hindering dependence upon the more physiological manual methods, which, moreover, are always more readily at hand, requiring only human arms for efficient application.

3. In electric shock and drowning asphyxia is the danger and minutes are valuable.

4. In gas poisoning the danger is tissue damage to follow and the treatment is elimination by increased breathing. The recent use of CO_2 and O_2 is a valuable discovery.

5. In anesthesia collapse both these dangers are factors but free breathing is most imperative.

6. To save the reputation of the Medical Profession as being interested and equipped to save lives *teaching Manual Artificial Respiration*—and, preferably, the Prone Pressure method, should be encouraged. This especially to doctors in hospitals, to first aid crews among policemen, firemen, and in the industries; to other laymen having first aid interests.

DISCUSSION.

Dr. R. R. Sayers, Washington, D. C.: Gentlemen, you certainly have heard a most excellent paper and something that you ought to really take to heart and follow up. I want to review just a little bit of Dr. Pinneo's paper before I come to the thing I want to get across to you people, and I have only one thing I want to get across; the other things are all incidental. In life, there are certain things that are necessary. We must have food, we can do without it for a matter of weeks. We must have water, and we can do without that for a matter of days. We must have oxygen or air, and we do without that for a matter of minutes. That is the relative importance of those things. That is the relative import-

ance of those things that you must keep in mind in treating people that are in need of those things.

The doctor has called your attention to the fact that changes in the composition of air affect men, probably in somewhat the relative proportion that changes in food affect men and that changes in water affect men. Take an increase in oxygen of about 21 per cent.; 20.93 is considered normal. You can breathe 100 per cent. oxygen for eight hours a day probably for quite a long time—for several days. We know that you can breathe it two or three hours a day for almost indefinitely, but if you breathe 100 per cent. oxygen for about three days you will develop pneumonia, edema of the lung and pneumonia. Take a decrease in oxygen—the doctor has called your attention to about where it begins to affect; about 14 per cent. When you get down to about 14 per cent., you get a little increase on exercise; that is, when you go to about 5,000 feet of elevation, you get an increase when you exercise. But you can under special conditions, Dr. Holdaine of England has shown breathe down to three and one-half per cent. and not lose consciousness. That is awfully low, but that is under a special condition. Under other conditions, Dr. Holdaine could only breathe down to nine and a half per cent. The Army Medical Research Board have shown that in certain men (and it varies with the man) they could breathe down to five and a half per cent. and retain all their mental faculties.

Let us consider changes in other compositions. Take carbon dioxide. Dr. Pinneo has called your attention to the increases. Three per cent. will cause panting, rapid increase in respiration. I believe they claim about 300 per cent. in the lung ventilation. Ten per cent. can be breathed, and he called your attention to the fact that it was extremely laborious. Increase in oxygen does not particularly help you. I have breathed 10 per cent. carbon dioxide in oxygen for forty-five minutes. Dr. Yadel Henderson told me that was a record. I didn't know it, or I wouldn't have made it.

Dr. Pinneo has called your attention to the various methods that might be used for protection against other gases. Carbon monoxide, and hydrogen sulphide are very poisonous and will cause you to stop respiration within a very short time, depending upon the concentration of the gas in the air. If you have as much as twenty-five hundredths per cent. carbon dioxide in the air, in thirty minutes you will have more than half of the hemoglobins of the blood combined with that carbon monoxide, and probably within a few hours, four or five, death will ensue, if you don't give some method of artificial respiration. I am not going to take up the other two or three gases, but I do want to bring this out: if you take in these various methods of respiration that the doctor has called your attention to, you can use any one of them and be successful with it if you know how to give it properly. We think that certain methods are better than others and therefore recommend them and teach them.

I had nine cases of cyanogenic poisoning at one time. I happened to be one of them. But I had 120 men to give the Sylvester method; I hadn't trained them in the Schafer method.

All of the men recovered. One man had it an hour and thirty minutes before he resumed normal respiration. He took gas now and then during that time. But it will work. All our men know how to give Sylvester's method. I have seen it in anesthesia, and it worked all right in that. Other men will tell you it is a good method. We teach, and have taught to 115,000 miners in the United States (and that is quite a crowd), the Shafer method of artificial respiration. They know how to give it. There are minor changes, and various methods of teaching it. We teach it in a definite way. They learn it and use it, and it comes out all right. They have used it on drowning cases. I could cite exact cases, but won't. They have used it on electric shock cases. I have had reports of cases come in within the last week on carbon monoxid poisoning, hydrogen sulfide poisoning, and anesthesia, from bootleg whiskey. That took three hours and it was done in Alaska, but the man recovered.

There are only two things I want to get across to you. They told you about carbon dioxid in oxygen in removing carbon monoxid from the blood. Five per cent. is what is recommended by Dr. Yandel Henderson at the present time, and I agree it is far better to use that quantity than the higher percentages. Eight per cent. is probably all right, but five per cent. carbon dioxid in oxygen will remove the carbon monoxid from the blood about five times as rapidly as will normal air. From the experiments we have carried out, we find that pure oxygen will remove carbon monoxid from the blood about four times as rapidly as will normal air. Therefore, if you have not the mixture present, use oxygen, and you nearly all have it in your hospitals, it is nearly always available; you can nearly always give it and it will work. The fact of the matter is I couldn't tell the difference between the carbon dioxid and the oxygen with regard to my own symptoms and the relief of them and the after-effects or the time of recovery, or in the effect they had on animals—dogs. Nichelo of France has used oxygen and very recently he reported that he gets the oxygen to remove the carbon monoxid from the blood five times as fast as ordinary air.

There are a great many laymen in this country who know how to give artificial respiration better than the bigger percentage of the doctors. Any of the young fellows coming out of the schools don't know how to give it. I didn't, and it isn't so awfully long since I came out. And there are lots of others in the same position. Recently one man told me that he had instructed his men (he belonged to a gas company), when they went out to see a gas case to go ahead and give the artificial respiration, even if the doctor came up and told them not to, and they went ahead and he sued them and put them in jail for it. That has happened. That is a serious condition. The thing for all of us to do is to learn how to give it, and everybody else ought to know how to give artificial respiration and give it properly. In fact, I would like to see it taught in the schools. That is the only thing I wanted to get across to you.

Dr. Daniel Strock, Camden: It may be an individual opinion, but I think this is one of the most important subjects that can be

brought before the attention of this Society. There will be other subjects presented before the day is over that will seem to some individuals probably more important than this, but as we are all engaged in life saving, I don't know of anything that could attract and demand and retain our attention more than this. We meet with accidents on all occasions, and those accidents result in the death of the individual if something isn't done promptly. For that reason, I think this is a very important paper. Any of you who have come in contact with the type of cases that have been mentioned in the paper of Dr. Pinneo, and in the discussion that has followed, will realize that prompt efforts at rescue must be instituted. I am not going to speak about the technical features of this paper, to give you any idea of how much oxygen it is necessary to use, or what the carbon monoxid will do. That has been told to you. I would like to relate some of my experiences. It has happened I have been called upon to see a number of cases of carbon monoxid poisoning, and some cases of electric shock—some fatal, and others not—and at least one case of drowning.

I want at this point to bear testimony to the work that has been done by Mr. Van Brunt, the Safety Director of the Public Service Corporation. He has gone all over the State, wherever employees of the Public Service Corporation can be found, and taught them the Shafer method, which in my opinion is the only method that we can safely resort to for resuscitation. Certainly the layman cannot be trusted with any other method. I have seen two cases where other methods than the Shafer or the Sylvester were used, where the individual had no chance whatever of life, in my opinion. Only last week, while speaking to a prominent man in Camden, he said, "I have every reason to believe that a man that I saw in Trenton last week was really killed by the effort that was made at resuscitation." That, of course, refers to other methods. It seems to me rather incongruous to speak of other methods and to speak disparagingly of them to this audience when we know that there are other methods being shown in this building.

Speaking of other methods, you know we simulate normal respiration, no matter what method is resorted to, for restoration of those who are seemingly drowned or asphyxiated by gas or whose respiration has ceased as a result of electric shock, fourteen, sixteen, or possibly eighteen times a minute. With the artificial respiration, other than the Sylvester or the Prone method, I have seen efforts made where the respirations were carried up to sixty and even seventy minutes. What was the result? The lungs were ballooned. Take the little gas balloons that you see the children playing with, and I saw them by the hundreds last week in Merchantsville at their fiftieth anniversary. You can blow them up to a certain point and then you can't blow them any more or they will explode, and one exploded within two or three feet of my face. That is what occurs in excessive effort at respiration in the lungs. The lungs are bang full of air; none can come out and none can go in. The result is that there is no circulation. And what chance has that individual under those cir-

circumstances? You can figure it out for yourselves. In two cases that I saw, just that occurred. It happened that I was sent for as soon as the accident occurred but, of course, it was some distance from my place and I couldn't reach there until others, who supposed they had some knowledge of the use of certain instruments, were working at it to this extent: bloody foam was coming out of the individual's mouth and here was no chance whatever for recovery. Take the case that I was told about in Trenton. That indicates that I have personal knowledge of three individual cases where there was no chance of recovery because of the use of means other than the Shafer or Sylvester methods.

You know what a terribly fatal thing carbon monoxid poisoning is if prompt aid is not given. We had a case of profound carbon monoxid poisoning a few months ago. The efforts were made not by me personally, but by one of the individuals whom Mr. Brunt had taught. The man was breathing normally and he wanted to go home. He had been sent to the hospital and I met him there. He was not allowed, of course, to go home. He was told that he was not in a fit condition to be allowed to go home. "Oh, yes, I am," he said. Anyhow, before he had finished asking to go home, he ceased to breathe and in a moment he was unconscious. Of course we turned him over immediately on his abdomen and resorted to artificial respiration. He began to breathe after about a minute of that work. This is the point I want to bring out: within twenty-four hours he had something like fifteen to eighteen of those attacks during which he was unable to breathe and in a moment or two was unconscious. So that I kept a relay of expert men with him day and night for an entire week. I asked him, "How do you feel when this attack comes on? Why don't you breathe?" He said, "I can't." He was utterly unable to get air in his lungs because of the temporary paralysis of the muscles of respiration. Yet he was conscious of that fact, and soon became unconscious because of the lack of air.

Dr. F. R. Haussling, Newark: I would like to discuss this subject from the angle of a surgeon. I agree with all that has been said about the lack of knowledge of artificial respiration, and the indications. In the operating room if you see a patient cease breathing during the administration of ether anesthesia, the operating room becomes excited. They order cardiac stimulants and they cry out for oxygen. Perhaps the oxygen is very accessible, and perhaps it is not. In the last twenty years I have tried to impress internes with the fact that the one and only way to resuscitate a patient who has ceased breathing during ether anesthesia is by means of artificial respiration, and we have always used the Sylvester method, and it has proved very efficacious. But I am sure that some lives might have been saved if instead of using these other procedures, artificial respiration had been promptly instituted. Of course, in abdominal operations it is difficult to shift the patient onto his abdomen.

Dr. Mefford Runyon, South Orange: I would like to say a word as to the business of the

doctor with regard to being an educator in this matter. During the summer time, I sail a boat. I have seen a great many cases of drowning. I have had more experience in artificial respiration in that accident than in any other. And it is appalling when you realize the number of cases that die because people who are present at the time the victim is first taken out of the water are unable to give the proper care. In the last two years, I have made it my business in the summer time to get as many boys and girls together as I could and I have taught them this method of artificial respiration. It is a little difficult to do, but that is the opportunity the doctor has, if he will take advantage of it wherever he can. The doctor has more time perhaps during the summer than at any other time of the year and during that time he can make himself primarily a teacher. And it is astonishing to note the interest that these young people take in acquiring a knowledge of this method. It seems to me in that way perhaps we could save more lives than we are able to by our own individual efforts.

Dr. A. J. Mitchell, Newark: As you all know, the Newark Police and Fire Departments have what we call "lungmotors." The question arises in my mind as to whether we, as a body, should condemn the practice of buying lungmotors for the Police and Fire Departments. After what has been said here, it seems to me that it is the wrong thing to have them unless they are used in the hands of experienced men. Unfortunately, because of the press and the politicians, if we don't have lungmotors and there is a drowning case or a gas poisoning case and the patients dies, the department will be condemned. I think this would be a good place to fight that question out at the present time: as to whether or not the cities should go to the expense of buying these so-called apparatuses and using them. Personally, I believe there is only one thing and that is the Shafer method, from the experience I have had in the Police and Fire Departments, and I think that if the Medical Society comes out as a body and condemns all other methods, we will not only do a lot of good for the public at large, but we will save the cities from going to the expense of buying some of these, as I call them, "worthless apparatuses."

Dr. Stock: When I spoke before I didn't say a word about the Shafer method. I wanted to say something about it, about its desirability, because of its rapidity of action. To illustrate that, two or three months ago I was called out at midnight. It was cold. A man had been working in a trench and in some way or another a gas pipe was uncapped and he was almost instantly overcome with gas and fell into the water unconscious. Fortunately, some of his comrades saw him. They took him out. They didn't wait for any artificial apparatus. They turned him over on his abdomen, on the cold wet pavement, and began to work on him. By the time I was called and reached there, he was breathing practically normally. I had him sent to the hospital and kept him watched, for the same reason that I watched that other case I told you about, all that night and the next day. He had no relapses and got well. That is the

point: if you are to rely upon apparatus you probably wouldn't have it with you in all these cases that occur and you would have to send for it. Time would be lost. For that reason, I think not alone every policeman and every fireman and every doctor, but even every school child should be taught the Shafer method of resuscitation. Children go to school and also go to swim. Many a child, or practically a child (they are not probably past twenty-one, and I consider them as children), when they go in to swim have to depend on their own resources to escape danger. If those children had a knowledge of such a simple thing as the Shafer method of resuscitation, probably we would save lives that other wise be lost. For that reason, I think that it should be part of the curriculum of schools to teach the Shafer method. Certainly every doctor should know about it, and yet how many do? I venture to say that comparatively few have ever seen the method illustrated and I can't too strongly urge upon you to avail yourself of the opportunity that is given at this meeting to see the process put in action. What the surgeon has just said is correct. In Merchantville—I don't live there, but I was called there at the fiftieth anniversary and made a little address to them; but I was told about this afterwards, and I subsequently gave a little talk about this subject to the Parent Teachers' Association—I was told by somebody that we have to have these apparatuses in our Fire Department because if anything went wrong and the individual died, we would be blamed for not having used this vaunted method of resuscitation. Therefore we should make an effort to teach our people, wherever we live, the importance of the Shafer method as compared to the undesirability and uncertainty of this method which, in my opinion, has caused many deaths.

Dr. F. W. Pinneo: Dr. Sayer's experiences in the Resuscitation Commission and his work with Yandel Henderson have given him a valuable background for his knowledge of the subject. His further experience practically in the Bureau of Mines is illustrative of what the Government and the industries have found. Answering Dr. Mitchell, if the gas companies and the electric light companies of the United States and Canada, subject to the same lawsuits for neglect as anybody else—and nobody ever thinks of suing a Government for anything, or of holding an individual responsible for lack of what is thought to be necessary apparatus—take the ground that they can do away with those ineffective methods, it seems as though you as taxpayers and the administration of the Government need not fear advocating better methods. The experience in the operating rooms of the hospitals has been illustrated by Dr. Haussling. This no doubt is of valuable assistance to those who are associated with hospitals. Remember, we are not arguing today for one method as against another. What we are trying to do is to show you men, the Medical Society of New Jersey, the necessity of artificial respiration for resuscitation, and the means of teaching it, so that the laity will not be saying you doctors don't know how to save lives, and so the manufacturers will not say, "We have the only thing that you can have in your insti-

tutions or on your streets." What would have become of Dr. Strock's last case that he mentioned if they had had to send to the police station or to a hospital for an apparatus? Getting back to the pathology, you will see that whatever the pathology of these cases may be, all of them demand artificial respiration, and promptly, and in cases of electric shock and drowning, it is the one insistent, imperative thing, and the only thing that will save life.

TREATMENT OF PULMONARY TUBERCULOSIS BY ARTIFICIAL PNEUMOTHORAX.*

By M. J. Fine, M.D.,

Director Division Tuberculosis, Newark Department of Health; Phthisiologist, Newark City Hospital and Beth Israel Hospital; Instructor of Medicine, New York Post Graduate School and Hospital.

Newark, N. J.

Quite regularly we read of a new treatment, method or cure for tuberculosis by drugs, chemicals or vaccines. These discoveries are highly lauded and given quite some publicity for a short time and thereafter are never heard of again.

This is not to be the case with the use of pneumothorax. Since its adoption by Forlanini in Italy in 1882 and John B. Murphy in this country in 1898, it has been used more and more extensively by a great number of phthisiologists with success. Some complications have been reported but all agree that pneumothorax has come to stay at least as an adjunct in the treatment of the disease. Its benefits are produced by giving the affected part of the lungs a much needed rest through the introduction of air into the pleural cavity, thus preventing expansion of that lobe or lung and holding it as if it were in a splint.

I have been using artificial pneumothorax more and more for the past four years in over one hundred cases and gave about a thousand refills. As many others, I originally employed artificial pneumothorax solely as a method of arresting hemorrhages. It is a well-known fact that mechanical pressure is more efficient in arresting hemorrhages than other means, particularly if the pressure is applied internally by the injection of air. Gradually I began to use it as a method of treatment in far advanced cases regardless of whether there was a unilateral or bilateral involvement. In bilateral I selected the most advanced

*Read at the 158th Annual Meeting of the Medical Society of New Jersey at Atlantic City, June 6, 1924.

side for collapse and the results in some were gratifying.

If an artificial pneumothorax in the graver stages of the disease, when exhaustion has set in, is beneficial, it is of course doubly valuable in the earlier stages. In the first place, pleuritic adhesions will be less probable. In the second place, rest will be given to the diseased lung at a time when power of resistance and recuperation are still at high tide.

Many writers advocate the usual treatment of tuberculosis, that is, rest, fresh air, good food, etc., and consider that in view of the fact that the induction of artificial pneumothorax has so many contra-indications and so many sequelae that it aggravates the patient's condition. There can be little doubt that the induction of artificial pneumothorax is just as safe in the hands of an expert as a lumbar puncture for diagnostic purposes. You would not for a moment hesitate to explore a patient's chest if you thought that he had pleurisy with effusion, as a diagnostic aid. I punctured many chests before I attempted giving artificial pneumothorax without noticing any vital shock or collapse. Generally speaking, I am giving artificial pneumothorax much earlier than is now the usual custom.

Murphy, who has made such great contributions to the artificial pneumothorax states: "Compression of the lung by artificial pneumothorax is now the dominant treatment all over the world because it places the diseased lung at rest. When shall we use this treatment? I was shocked a short time ago to read that some of the ablest men suggested it as a treatment for pulmonary tuberculosis when it had not yielded to other means. The old appendicitis proposition all over again. Why must we wait until there are cavities in the lung? Why must we wait until there are hemorrhages? Why must we wait until a whole lobe is involved? Use it now and early."

Beggs states: "My own experience as assistant, principal or consultant in about one hundred cases of pulmonary tuberculosis treated by induced pneumothorax, almost all of them in advanced states, convinces me that a decidedly earlier treatment by this method is very much to be desired. It is a matter of universal recognition that the further the disease has progressed the greater the liability to find extensive adhesions or even total obliteration of the pleural space, even though either may exist in

early cases from previously occurring pleurises."

Complications such as have been described by those who are doing artificial pneumothorax, which cause the treatment to be ineffective or to be stopped, are much less frequently met with in early stages of the disease. Firm pleuritic adhesions, the common interference with the procedure of treatment, in the way of success, are not by any means so great.

If you are of the opinion that a case ought to have an artificial pneumothorax, it should be administered, even though the x-ray shows adhesions, and often you will find that by so doing you will meet with success. We now know that the danger incident to the administration of air is practically negligible if the treatment is properly given. Exactly the same measure of safety is involved in the effecting of a series of partial collapses. To give a patient a partial pneumothorax and continue the treatment every week for a few months at least, is wise and beneficial.

The early use of partial pneumothorax is particularly indicated for the incipient cases which in spite of the most careful treatment show little improvement, and for those who respond to complete rest, yet develop clinical symptoms and physical signs with the least exertion. My experience with partial collapse has led to the formation of the following conclusions, similar to those of Barlow and Kramer, described in the American Review of Tuberculosis: Partial pneumothorax is efficient in securing fibrosis around the diseased area. Such fibrosis tend to be permanent under the partial collapse. Partial pneumothorax also affords to the affected lung the maximum rest possible. It is well to remember that a lung expands and contracts 12,000 times a day, a process of continued activity that must be arrested if the lung is to be given an opportunity to heal.

A partially collapsed lung shows a decreased tendency to adhesions and it is less in danger of the development of a spontaneous pneumothorax. In the administration of such collapse, the physician collapses only diseased tissue allowing healthy tissue to function. There is also eliminated the danger of the displacement of any organ and the danger of any injury to the mediastinum. Complete artificial pneumothorax does involve these dangers. A partial pneumothorax may be used alternately in either lung. Among the reasons for the partial pneumothorax, I mentioned that the maxi-

num rest is given to the diseased parts. This has been demonstrated many times, especially where the infection has been located either at the upper or lower lobes. The air has a tendency to first collapse the weaker portions, thus leaving, with the partial method, the healthier portion free to perform nature's functions and give rest where it is most needed. The contra-indications present in the case of complete collapse such as dyspnea, dizziness, fainting, nervousness or tachycardia, are not apt to manifest themselves as much as in complete collapse.

I have attempted to induce artificial pneumothorax in 102 cases of pulmonary tuberculosis. In 26 advanced cases it was impossible to produce a pneumothorax on account of adhesions. In 12 I did likewise. All of these were moderately advanced and no improvement noticed after several injections; another case the pleura was so cartilaginous that it was impossible to penetrate. In the latter case the x-ray showed a greatly thickened pleura; twenty-nine of these showed slight unilateral involvement and five of these showed adhesions which did not prove obstacles to treatment. Thirty-four were moderately advanced cases. The oldest patient was 68, the youngest 10 years. Only in one of my cases a complication has arisen, that is the development of fluid after the second injection; I aspirated the fluid and replaced by air, and treatment continued. Numerous other observers reported such complications as pleural shock, embolism, spontaneous pneumothorax empyema, etc. It seems that I have been more fortunate in my cases in which pneumothorax was done. The probable explanation may be due to the fact that pneumothorax was done early in the disease.

The method of procedure is as follows: Preliminary to the injection a $1/4$ of a grain of morphine sulphate and $1/150$ grain of atropine sulphate is given 15 minutes before the operation. The site of injection is then washed with alcohol and then anesthetized with novocain and adrenalin. I use the puncture method in preference to the skin incision. The location of the puncture, of course, depends on the physical signs and Roentgen findings. When possible the axillary line is used, as there is less muscle and fat tissue on this site. The first injection is given at the patient's home lying in bed. An associate records the pulse, watches the manometer and looks out for unusual symptoms. When the manometer shows the proper reading, 50 c.c. of air is given. How-

ever, irrespective of the manometer reading if the patient complains of pressure or discomfort the treatment is discontinued. The subsequent treatments are given once a week at the office, if the condition of the patient permits. The advantage of office treatments is that we may have fluoroscopic control. It seems that there is an advantage of performing the operation with the patient sitting in a chair, his legs astride, his back toward me, his face toward the back of the chair, and his chin resting upon his folded arms on the top of the chair. I have noticed that this position has a tendency to spread the intercostal spaces, and thus allow freer access. The refills are done on an average of once a week. A needle I use is one with the two-way stopcock described by Rosenblatt. The advantage of this needle is that anesthesia can be produced and the air introduced without removing the needle. The metallic safety clamps is a useful addition to the pneumothorax needle. One is able by placing the guard at the point of the needle to control the desired depth.

Most of the workers in the field in their written statements do not definitely state how long the treatment should be kept up. In my practice, I have discontinued treatment after six or seven months. In three cases it became necessary to re-establish a pneumothorax. It might be interesting for the association to know that none of the cases were in a sanatorium during the entire course of the treatment. Of the 29 early cases of tuberculosis, 12 are at work and the rest are improved. Only three of the moderately advanced cases are at work. One must come to the conclusion that the earlier the pneumothorax is begun in the less advanced cases by this method described will lead to better results and bring pneumothorax to its proper place in the treatment of tuberculosis.

The wider experience of artificial pneumothorax in the earlier stages of tuberculosis might be efficacious. In this way danger, complications and sequellae of the process induced in a later stage would be obviated and incidentally given the lungs a maximum opportunity to rest and heal. Further, I am confident that partial artificial pneumothorax, practiced in the incipient stages, induced regularly and periodically and continued over an extended period of months instead of years is the rational and most satisfactory treatment of this disease when it effects the lungs. Its many advantages, its more favorable prognosis, its slight

degree of discomfort to the patient and its promise of developing so safe and sane a technique have made the practice the "sine qua non" of my practice.

175 Clinton Avenue.

DISCUSSION.

Dr. Alexander Armstrong, White Haven, Pa.: Mr. Chairman and Members of the New Jersey Medical Society: Dr. Fine has described a method of treating tuberculosis which is recognized by all those who are now treating tuberculosis in large numbers as a distinct advance over what is known as the "rational treatment." This does not mean that we have abandoned the rational treatment by any means, but there are certain number of cases which do not seem to be able to get control of the disease by what is known as the rational treatment, which he has described also, that can be benefited by the compression of the diseased lung or the diseased area in either lung. We therefore tried to select only unilateral cases and we waited, I am afraid, too long for this treatment to benefit many a case.

Dr. Fine has been criticized to some extent because he is using this treatment in cases that are considered very early or that have had some very slight symptoms, as for instance slight blood spitting. If he uses it only to control the bleeding in slight blood spitting, which we have all considered a self-limited thing, which will cease if the patient is put at rest, then I think he is possibly going a little too fast or too far. If, however, he is considering the slight blood spitting as a symptom of activity of tuberculosis and he compresses that lung with the idea of continuing to compress it until the patient has fully recovered, then I think he is justified in using compression of the lung or artificial pneumothorax for slight hemorrhages.

I want to say right here that I am one who is now refusing to give this treatment as a last resort. We have been doing this sort of thing at White Haven since 1912. We have had a great many hundred cases and some four or five thousand re-fills. Our staff in White Haven will refer these cases to me when they have tried everything else and when the patient is almost ready for the undertaker. When I was younger and more enthusiastic, I took a chance, and the result is the treatment got a bad name. My rule is that if a case with signs of activity (we will hope it is only in one lung) after six weeks of absolute rest in bed under ideal conditions does not definitely improve—I mean by that reduction in temperature, increase in weight, cessation of symptoms—the artificial pneumothorax should be tried. I want to say further we don't have to stick absolutely to unilateral cases. Given an old lesion in one side which is quiescent partly held or entirely held, and a new lesion, or the present lesion in the opposite side, we can ignore the fact that the other lung has been damaged somewhat, but it must be watched carefully.

I disagree with Dr. Fine in one or two other particulars. It is not an entirely harmless procedure. Gentlemen, you must remember that we are piercing a serous membrane and

it should be considered as a major operation. Dr. Fine's experience hasn't been of quite as long duration as mine. We have had three operative deaths in our series of about five hundred cases. When you consider, however, that there were about 4,500 actual operations, that isn't a high operative mortality. I have also had a great many cases of pleural shock, so-called. I have had one distinct case of embolism in which the case became paralyzed, lost power in one side; this patient however, recovered and is living and working. As I say, it is not a harmless procedure and every care should be exercised in the operation. I therefore object to the plan that the doctor suggested of having the patient sit up. I know it is done, and has been done for years. I insist that every patient shall be lying down on his back or on his side. So it is not entirely a harmless procedure. You all know of patients who have died from the operation of aspiration. I think this is to be considered, as I say, as a very definite advance in the treatment of tuberculosis. But the cases should be carefully selected and the operation should be conducted with all possible surgical care.

Dr. Fine, closing: I am glad that Dr. Armstrong called attention to what I said about hemorrhages. I give artificial pneumothorax only as a pretence for his hemorrhage, though I am actually giving it for his advancing tuberculosis. In cases where artificial pneumothorax is necessary, when the patient sees a little blood, he is almost ready to do anything, and when you suggest artificial pneumothorax to stop the hemorrhage, telling him his condition will improve, he will consent to the operation. As far as the operation being entirely harmless is concerned, I didn't mean that. It is harmless, in the hands of an expert, and when the expert applies it I think it is harmless. In the thousand re-fills that I gave, I didn't see any bad effects whatsoever. The only bad effect I had was in one case—Doctor O'Connor's case, of Harrison—that developed fluid after the second injection, and when I withdrew the fluid, we continued the treatment and the patient kept on improving. I also agree with Dr. Armstrong that the induction of artificial pneumothorax should be applied as a last resort, and I urge every doctor who has a case that doesn't do well under the ordinary treatment to try artificial pneumothorax, and not to let it go until it is too late.

GRADUATE SCHOOL OF MEDICINE EXTENSION COURSES.*

By Alexander MacAlister, M.D.,
Camden, N. J.

With the successful inauguration of graduate medical extension courses, it would seem that the cry of the rural districts for more general practitioners and the cry of the rural practitioners for greater opportunity for advancement has been

*Read at the 158th Annual Meeting of the Medical Society of New Jersey, June 6, 1924.

heard and is on the way of being answered. We have only to take a glance over to our neighboring State of Pennsylvania to get an idea how this progressive movement has been set in motion and with what success.

Under the direct auspices of the University of Pennsylvania and sponsored by the Medical Society of the State of Pennsylvania and the County Medical Society, the past two years have seen the movement working with a degree of success which augurs well for the future, based as it is on the enthusiastic earnestness of the teaching force and the student body. There is no reason that I can see why the medical profession of the State of New Jersey should not fall in line with a progressive movement of such importance and far-reaching significance. The *modus operandi*, as developed in Pennsylvania is simple and effective. Let me give you a brief outline of the same. The plan provides for certain types of extensive instruction in Philadelphia and the University Graduate School of Medicine, and in local centers throughout the State. It is the latter aspect of the subject which I wish particularly to dwell on.

The work in the local centers comprises a course of instruction extending over two years, consisting of 150 hours during a period of five weeks in each year. This means giving up only one day or part of a day a week to the actual sessions. These consist of clinical conferences and lectures on the topics discussed at the conferences. The sessions are held in a hospital located in a convenient center for physicians within a radius of about fifty miles in all directions, who form the group registrants or student body. The hospital agrees to provide the necessary space where the conferences or lectures are held and together with the group registrants, the clinical material, clinical services, etc.

The teaching is done by experienced men designated by the School of Medicine under whose auspices the extension work is to be conducted. There is no registration fee. The registrants, however, each agree to pay a per capita cost of the expenses of the group. Among such expenses are the honorarium of the teacher, which has been fixed at not less than twenty-five dollars per teaching day, and his traveling expenses; the services of a physician representative, or director, or executive secretary (whichever he may be called) who stands in direct communication with the Dean of the medical center which conducts

the course, attends to all other business of the group, such as seeing that the clinical conferences material is ready, and preparing substitute material in case of default on the part of the sub-group to whom the day's work has been assigned, and that the follow-up work is properly done; keeps the records of attendance, etc.; and the services of a stenographer or clerical assistant. The group registrants pledge themselves to attend at least 80% (40 of the 50) of the sessions and to perform their portion of the prescribed clinical work of the course. The registrants are divided into small sub-groups, each of the latter in turn being responsible for preparing the clinical material for a given session, the type of case having been previously indicated by the teacher.

The teacher arrives at the designated center in time to become acquainted with the history and to make the necessary examination of the patient or patients to be discussed before the actual sessions begin. The latter is held in the afternoon, and after presentation of the cases by the sub-group, the teacher opens the discussion which is participated in by the group and again closed by the teacher. The evening is usually occupied by a systematic lecture on the subject matter of the afternoon's conference. The sub-group is responsible for follow-up work on the illustrative cases of the conference.

The case records, follow-up work, transcripts of the stenographer's notes of the clinical conferences and lectures, the record of attendance, and the sub-group assignments, the reports to the dean, etc., are multigraphed on standard size paper, suitable for loose leaf binders so that when completed they represent a sort of "Book of the Course." The dean of the parent teaching body is kept supplied with duplicates of the above, and with confidential criticism by the representative upon the work as it progresses. The dean or one of his assistants visits the group as occasions may arise.

Each member of the group is considered a real student of the parent medical school, his record being kept just as that of a resident student physician, such as registration, matriculation, attendance, examination certification, catalog information, etc. The group registrants who have complied with the requirements for membership and have completed the course are eligible for examination and if successful, receive from the parent teaching body, "a formal ex-

ension course certificate of a non-display character on which are set forth briefly the pertinent facts."

In order to present the latter to you in a more succinct way, permit me to illustrate the actual workings of a such group of student physicians as organized in Bradford County, Pa., and conducted at the Robert Packer Hospital, Sayre, Pa. In 1921, came the offer of the Graduate School of Medicine of the University of Pennsylvania of non-resident post-graduate medical instruction. Through the mediation of the State Medical Society and local County Medical Societies this invitation was brought to the attention of the members of these organizations, and as a result of this invitation, four such courses were established during the University year 1922-1923. The one in Bradford County had an enrolment of 27 members. The course ran the required number of hours to the satisfaction of practically the entire group. Three of the group failed to respond to the questionnaire and only one felt that the advantages of the course had not been in proportion to the time given. 16 of the group had attended from 22 to 25 of the sessions. This is good showing considering that some had to travel as much as 40 and 50 miles to attend the sessions. In passing it may be said that some of the best records were made by these "long distance" travelers.

The course was arranged to meet the practical needs of the student physician. As expressed by Dr. Butler of the Robert Packer Hospital (to whom I am indebted for a description of the scheme as developed in Bradford County.) "Success was due, primarily, to the earnest efforts of the professors, who, at small recompense, conducted the clinics. They proved that they appreciated fully the needs, desires and limitation of their audience. The keynote of practicability was sounded in the very first meeting, a diagnostic clinic on thoracic diseases. Apart from eyes, ears, and fingers, only six items were brought into play—stethoscope, pocket flashlight, tongue, depressors, skin pencil, tape measure, clinical thermometer. The student members were assured from that moment that the course was designed to really meet their needs. That confidence was never shaken. Tact, patience, careful review, practicability, all characterized the presentation of the subject matter. The teachers put their best efforts into the work and the students derived great returns."

No less a factor for the success of the

sessions was the conscientious and effective work of the parent executive office that planned and controlled the general policy: (1) The schedule and allotment of time were made to conform to the reasonable desires expressed by the group; (2) the subject matter was selected with a view to the best interests of the student body and was handled with logical consideration and kept within the field of the general practitioner who cannot be expected to have laboratories, x-ray equipment, electrocardiograph stations, etc.

The Robert Packer Hospital evidently satisfied the third essential item for success—the teaching focus. In addition to its accessibility, its organization is peculiarly adapted to the purpose of extension teaching. It is a "closed hospital" with one man in undisputed professional command, and a clinical organization on a full time basis. The hospital comprises 235 beds with active diversified services adequately equipped, all of which were immediately placed at the disposal of the group. In this instance the representative and secretary or director of the group registrants was a member of the Clinical staff of the hospital, who kept in touch with central body at Philadelphia and arranged the details of the session. The clinical material was always ready for the sessions, and mimeographed copies of the cases histories were ready for distribution to the student body. While the advantages of this arrangement are obvious, the disadvantages, as pointed by Dr. Butler, are that "the individual participants in the course lost one of the primary benefits—training in careful history taking and physical examination."

In view of the fact the scheme is still in its experimental stage, we are fortunate to be able to profit by the suggestion of the Bradford County Group. Dr. Butler in his description of the plan thinks it advisable for the local administration to be in the hand of a director whose duties shall be: (1) To act as liaison officer with the parent teaching body; (2) to prepare the clinical material for each meeting and to have ready a substitute program in case a sub-group default on its particular day. The director, of course, must have the active and whole-hearted support of his group.

The low actual cost to each member is an item that requires special emphasis. To the Bradford Group this amounted to \$60 for the 25 meetings, less than \$2.50 per meeting. As this was an item that could not be decided in advance, each member

was required to make a deposit of \$75 to the Treasurer, with the understanding that any per capita surplus would be returned and any deficit would be met by an extra assessment. The itemized expenses comprised: \$625 Honorarium for the teacher; \$725 traveling expenses of the teacher; \$25 incidental expenses, postage, supplies, etc.; services of stenographer. This amounted to the nominal sum of \$10 per month as extra compensation to the hospital stenographer. These items do not include the expenses of rent for the meeting place, secretarial duties, stenographic services, all of which were generously donated by the staff of the Robert Packer Hospital.

There is every reason to believe that graduate extension courses in medicine have come to stay, at least in Pennsylvania. Let New Jersey be the next in line to carry out this ideal in medical efficiency, whose object is "not so much to teach doctors medicine as to drill them in habits of care and attention to details," habits that must tend to suffer from the very nature of the work of these doctors, and habits which when neglected may be of serious and lamentable consequences not only to the patient but also to the doctor himself.

Abstracts from Medical Journals

Treatment of Epilepsy.—John McCartney (British Medical Journal, January 6, 1923) treated eighteen patients by the following method: The patients were put on potassium bromide ten grains, borax purificans five grains, and Fowler's solution two minims, three times a day. This dosage was gradually increased and the best results were obtained with potassium bromide fifteen grains, borax purificans 7.5 grains and Fowler's solution two minims, three times daily. A laxative was also given at bedtime. Continuous treatment given along these lines showed no deleterious effect on the health of the patients, producing no gastric or skin disturbances and even produced a general improvement in their physical condition.

A Treatment for Cancer:—During the month newspapers have carried the announcement that Blair Bell, professor of gynecology and obstetrics in the University of Liverpool, has described a preparation for the treatment of cancer, which has been successfully used in fifty cases. Later editions tended to correct this preliminary statement by interviews from American physicians. The fact is that Professor Bell described his experiments in the London Lancet last November. He had treated fifty patients with a solution called colloidal lead lecithin. This statement was based on the belief that combinations containing lecithin would tend to localize in cancerous tissue

and that the lead would have a specific effect in killing the cancer cells. Professor Bell had used the method over a period of two years and in only two cases was there apparent recession of the cancer; in two other cases possible benefit was reported. Because of the scientific standing of Professor Bell his work is of great interest, but he points out that it is wholly experimental; that it is merely being put on record; that it is suggestive only; and that there is no reason to accept the report as anything but a preliminary statement. Certainly the solution described cannot be called a cure for cancer, as it was characterized by the press.—M. F.

New X-ray Tube for Cancer.—The new x-ray tube for cancer treatment invented by Dr. C. T. Ulrey, research engineer for the Westinghouse Lamp Company of Bloomfield, N. J., promises to be a boon to cancer victims, not only in effectiveness but also in cutting down the high expense of treatment. This was the conclusion reached by experts after the new tube had been used successfully at St. Luke's Hospital during the past three months. Improvements being made on the apparatus are expected to result in great advances in the treatment of the disease. It has also been announced that another process is being perfected which would extend the use of the x-ray to internal cancer, for which no electrical treatment has yet been devised. This tube radiates five or six times as many curative rays as the ordinary tubes.

Prognosis of Angina Pectoris.—Ribierre and Leconte point out that the severity of subjective symptoms is not proportional to the severity of the prognosis. Even slight symptoms are important. Angina following exertion is a sign of aortitis. Its prognosis, especially in syphilitics, is less serious than in angina in the supine position, which indicates dilatation and insufficiency of the strained heart. Some patients have no other clinical symptoms, but a change in the depth of the aortic shadow may be found by radiology. The distinction between a true angina and a pseudo-angina is inexact and dangerous. Its only use is to calm the patient, whose condition might be seriously impaired if he should hear the diagnosis of "true angina pectoris." A sudden change of position during the examination (from standing to lying) may provoke an attack, and should be avoided.—Medicine.

Malarial Treatment of General Paralysis.—Askgaard reports complete restoration of earning capacity in 32.4 per cent. of thirty-seven cases and great improvement with partial restoration in 21.6 per cent. The disease has progressed in 3 per cent. and in 6 per cent., after a transient remission. Excluding the patients who were treated mainly for the purpose of keeping the malaria strain alive, the apparently cured total 38.6 per cent. and the improved, 26 per cent., a total of 65 per cent. benefited since the malaria treatment was introduced in October, 1922.—Kentucky Med. Jour.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

4 SOUTH DAY STREET, ORANGE, N. J.
Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

HAS. D. BENNETT, M. D., Chm., 750 Broad Street, Newark.

EDITOR:

DAVID C. ENGLISH, M.D.,
P. O. Box 83, New Brunswick

ASSOCIATE EDITORS:

CHRISTOPHER C. BELING, M.D., Newark
HENRY B. COSTILL, M.D., Trenton
JAMES HUNTER, JR., M.D., Westville
HARRISON S. MARTLAND, M.D., Newark
FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, New Brunswick.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

Pending further arrangements, all communications, including manuscript, should be addressed to Dr. C. D. Bennett, 750 Broad Street, Newark, N. J.

AN APPRECIATION.

Centuries ago the Biblical writer asserted his belief that "The days of our years are three score and ten, and if by reason of strength they are four score years, yet in their strength, labor and sorrow" and in the main:—his contention has been accepted as fair and correct, but in the case of our old friend and editor, it certainly did not apply. Dr. David Combs English, who passed away on September 19th, 1924, was truly a wonderful old man. Old in years he surely was, but in physical and mental condition, he was marvelously young. He was active and virile, his bodily movements were quick and energetic,

and his positive speech and resounding voice never failed him in expressing the thoughts which sprang from his ever working brain.

He had treasured up during his long life an enormous sum of knowledge, especially of affairs in medicine and theology and the details of this accumulation of wisdom and experience were always at his command. He was never at a loss to produce facts, arguments, history or precedents bearing upon the matter under discussion, and it was a rash debator who ventured to differ with him along the special lines mentioned. He had, moreover, the courage of his convictions and he never failed to impress his dominating impulse in favor of the position which seemed to him true and just. Yet withal, he was a kindly opponent as well as a hearty coadjutor. His victories he accepted calmly and his defeats, which were few, were also received without rancor and to be looked upon as probably affording the greatest good to the greatest number.

For many long years he was a power in the councils of the medical profession in New Jersey. Whether as a plain practitioner of medicine, as a member of the hospital staff of his home city, as President of his local medical society, as President of his county component society and later its Treasurer, as a President of the New Jersey Sanitary Association, as a Fellow of the American Medical Association, as a President of the New Jersey Medical Society, as a Trustee of the State Society, and as Secretary of its Board of Trustees, and as Editor of the Journal of the State Society, he was always efficiently at work. Being a willing and faithful worker, honors were thrust upon him. He was made a member of many important committees and well represented the Society at the meetings of the National Association and at many medical meetings in neighboring states. With all this his loyalty impelled him, even in his later advancing years, to become, during the Great War, a member of the Volunteer Medical Service Corps of the United States.

But he was a man of broad views and his interest in life extended beyond the limited range of medical affairs. He found the time to serve his city as alderman and was very active in religious matters. He had been a ruling elder in his church for 51 years and for 40 years had been clerk of the Session.

For many years he served as superintendent of the Sunday School, was a delegate to the General Assembly several times and also to the State Synod.

His long service in the church brought him a large knowledge of religious history and his opinions on church government were often sought for and respected by his colleagues. All these threads of activity were interwoven with the web of his true life work, that of caring for the health of those who entrusted themselves to his care.

He made his patients also his friends and strove to help them, whether they were rich or poor, of high or lowly estate, without much thought of monetary remuneration and only striving to render service where it seemed most needed.

It is a common saying in these days of changing ideals, that the medical profession has been commercialized, and to some extent this may be true but it certainly was not true of our departed friend.

He well represented the vanishing type of the old-time family doctor, who cared for his families as if they were his own, healed their ailments as best he could, rejoiced with them in their pleasures and successes and comforted them in their sorrows and failures and was at all times the friend and advisor of those who placed themselves under his guardianship. Truly a loyal protector, truly an ever ready help in trouble and truly a man to be painfully missed and mourned for.

A striking characteristic of Dr. English was his cheery optimism and his undaunted courage. Although in his 83rd year, he still worked and planned and fought for the welfare of his profession and never seemed to fear infirmity or decay, but lived on, from day to day, doing the best he could.

In a letter written but a few days before his unexpected death, he outlined plans for the coming year and was arranging his own life affairs as far away as July and August of next year. By such men is history made and the world bettered.

WHO IS HEALTHIER—THE CITY OR COUNTRY BABY?

"It is natural to think that babies in rural districts would be healthier than those in congested cities," says Dr. George T. Pal-

mer Director of the Research Division of the American Child Health Association.

"Despite its recognized drawbacks, the crowded tenement within the reach of good medical attention and with pasteurized milk delivered on the dumb waiter is pressing the farmhouse with its abundance of pure air and fresh milk for first honors as the best place for babies to begin life."

Dr. Palmer makes this statement following the publication of the infant mortality report for 1923 recently prepared by the American Child Health Association.

He continues: "According to the report country babies are still leading in the health race but city babies are gaining. The death rate for rural infants is lower than the rate among city babies in sixteen out of twenty-seven states for which records are available. But in nine states the baby death rate in cities of more than 10,000 population is actually lower for 1923 than in the rural communities as indicated by the provisional reports of the United States Bureau of the Census."

This is true in California, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, and Washington. The death rates are the same for both city and rural districts in Minnesota and Ohio. The cities have gained in this indication of healthfulness since 1922. In that year only five states showed lower baby death rates in cities than in rural districts.

"Great credit is due the cities in these East and West Coast States for overcoming their natural disadvantages," says Dr. Palmer, "and by progressive public health work involving pure water and milk supplies, extensive educational work through hospitals, clinics and nursing associations, to have materially cut down their baby death rates even below those of country districts."

Dr. Palmer urges complete registration of births as one method of reducing baby death rates. He explains that if the birth registration records are incomplete a community frequently does not receive the credit which it deserves. At the present time only 31 of the 48 states and the District of Columbia are in the Birth Registration Area, the territory in which birth records are filed with such accuracy as to be officially recognized by the United States Bureau of the Census.—American Child Health Association.

CURBING THE QUACK.

From N. Y. Tribune, Aug. 28th.

The application by Magistrate Vitale of the statute making illegal the use of the letters "M. D." by any other than a graduate and licensed physician ought to be followed up by the arrest of all the charlatans who have been preying on the people of the tenement districts. The man who was held for trial in this case in point had charged a poor woman \$30 for examining her chest with a stethoscope and taking a drop of her blood for "examination."

There are hundreds of ignorant and unlicensed practitioners of various sorts in New York, many of whom do not hesitate to print "M. D." after their names on cards and window signs in order to attract patients. Most of these fakers, like all successful charlatans, are imposing in appearance and have acquired a line of highly impressive conversation.

The harm that can be done by impostors of this sort is limited only by their ability to secure victims. Many of them build up large practices among the foreign born and illiterate population, taking care in the event of a death or of a dangerous malady to call in a regular physician, and thus save themselves from attracting the notice of the authorities.

If they did no more than obtain money under false pretense the necessity of putting them out of business would be self-evident. But too frequently the treatment they administer is extremely dangerous, and often leads to the death of those they have gulled. In a great city, always menaced by epidemics, none but trained physicians should be permitted either to prescribe for or treat the sick. It would be well for the police to follow up this decision of Magistrate Vitale's by gathering in all the quacks in the city and presenting the evidence against them to the grand jury.

CORRECTIONS.

In the Official Transactions, as published, there are two errors noted:

On page 11, in Payments, 1923—"Transferred to Capital Account," should be \$10,000 instead of \$1,000.

On page 43, in the Budget for 1924-1925, the first two items should read:

Allowance for Committee on Publication, \$2,500 instead of \$25.00.

Allowance for the Welfare Committee, \$4,000 instead of \$40.00.

Communications.

DR. W. P. EAGLETON'S TRAVELS.

We sailed from San Francisco on the "Tahiti" on July 16th. The weather was very cold. San Francisco is a very funny place as far as climate is concerned. One has to carry ones overcoat constantly. As soon as we got outside the harbor we ran into rather a severe storm which continued for two days, after which we had perfect weather until we reached New Zealand. This, they tell me, is the usual thing going through the tropics.

There are two ways of going to Australia from San Francisco, either by way of Tahiti, Rarotonga, New Zealand and Sydney, or by way of Honolulu. The route by Tahiti is about 1,300 miles further, but my experience is that the extra amount of time is well spent.

There was considerable sickness on the "Tahiti" on her northward voyage; a number of the men in the culinary department had influenza and pneumonia, and on the arrival of the ship at San Francisco, they had been transferred to a hospital where one of them afterwards died. On our trip southward, pneumonia again appeared, so the ship had had 8 cases of pneumonia in its complement in one round voyage. This is surely more than a coincidence and demonstrates that pneumonia itself, of the massive lobular type, is undoubtedly more or less contagious.

I was impressed with the high degree of intelligence and general efficiency of the medical officers, both on board ship and in quarantine, their resourcefulness, their ability to meet emergencies successfully, with a very limited surgical and medical equipment.

While at sea we heard of a dramatic incident. A small steamer, without any surgeon, had a case of appendicitis develop in one of its crew. The wireless operator picked up a passenger steam going in the other direction, the surgeon of which diagnosed appendicitis from the symptoms given in a wireless message and decided that the man should be operated. The two steamers met, the sick man was transferred to the passenger steamer, was operated on by

the surgeon immediately; the only inconvenience the patient apparently suffered was that he was taken back to the port he started from.

I had read all kinds of reports of the terrible heat in passing the equator. It was quite warm for one week while we passed through the tropics, but it was far from unbearable, and with the aid of an electric fan in one's cabin, everybody was enabled to sleep very comfortably. The humidity, however, was high, but as we got to the equator there was a fine breeze and this continued. I am informed this is the usual condition around the equator, lots of wind, no humidity but heat; it is the presence of a good wind that enabled the islands around the equator to be the earlier ones discovered, because the trading ships found that in this region they could always count on good winds. Later, it was the same condition that caused the free trading that occurred between the different islands.

The ship was accompanied all day by myriads of flying fish. They are about 6 inches long and they fly distances varying from 20 to 300 feet; they look exactly like a swallow; just before they return to the water they flap their fins. We also saw a few birds but did not pass a single ship all the way to New Zealand. The loneliness of the Pacific is a great contrast to a transatlantic voyage, where hardly a day passes without several vessels being sighted.

TAHITI.—We entered the harbor of Tahiti on July 24th at daybreak; it is a most thrilling sight. You are anchored in a race-way between the island and its fellow, Moorea, which is 12 miles away. They are both of volcanic origin, simply masses of rock thrown up out of the sea with a road around the edge of the water. Tahiti has been called "The Garden of Eden of the Pacific," and I think it probably deserves its name. It is under French administration and at sunrise the quarantine officer came aboard, a French doctor, and after examining us carefully allowed the ship to tie at the wharf. As in many French towns, the doctor is a public character. In the case of Tahiti he is a kind of "Poo Bah" of the town, for he is its mayor as well as quarantine officer. There are two other doctors on the island, but I understand that the mayor has most of the practice.

The drive around the island is 240 kilometres, 38 kilometres of which have to be done in a buggy, as there are 24 streams to be forded, there being no bridges in the northern side of the island. The centre of

the island is absolutely impassable; it is made up of a succession of mountain peaks that rise to a height of 7,000 feet, and only 9 miles away from the seaport of Papeete is one of the most beautiful water-falls in the world, a sheer drop of over 700 feet, and more water goes over it than from the Bridal Veil Falls in the famous Yosemite, yet few people have ever heard of it and fewer still visit it because it means a hard climb after you leave the road.

The island is well supplied with water because of its mountainous character and all the streams run straight into the Pacific. Anything will grow and everything apparently grows without being planted. You see bread-fruit, oranges, grape-fruit, bananas, and of course, cocoanuts on every side of you, and as far as I could make out they were all wild.

Tahiti is one of the Society Islands, and the tourist is always taken to a point of land called Venus Point, where Captain Cook made his observation on the transit of Venus in 1769, having been sent out for this purpose by the Royal Astronomical Society of Great Britain, and the islands are today called the Society Islands from the Royal Astronomical Society having equipped the expedition of Cook's which caused the discovery of Tahiti by a white man.

The capital of the island is Papeete and has a population of about 10,000. Ever since about 1840 it has been under French control. French is generally spoken. When I went ashore, as none of the natives apparently understood English and no one could understand my French, I went into a store and said to one of the clerks who looked like a half-breed: "Do you speak English?" His face brightened up and he answered: "Sure! Me been to 'Frisco. What can I do for you?"

The Tahitians are a part of the Maori race to which all the South Sea Islanders belong, and they are a wonderful people, highly intelligent and self-respecting. You do not see any beggars and they are the most courteous people. When one thinks that this Polynesian tribe used to migrate in canoes from one island to another, distances of 2,000 or 3,000 miles in the open sea, one realizes that they are natural seamen. The women have a great reputation for beauty—it is a thing of the past, found chiefly in books, and I am told on good authority that most of the tales that have been written about the beauty of the South Sea Islanders (women) during the past

few years, have really been written in the parlor of San Francisco by a man who knows very little about them. There is a book called "Isles of Illusion," which stresses this point, that most of what has been written is largely fiction.

Living in Tahiti is very cheap. You can get a very comfortable room for 50 cents a day and meals are about a quarter each. Nobody does very much work because nature supplies everything the natives want. There is a general air of indolence about the whole place. I thought it was confined to the natives, but apparently it immediately takes possession of any visitor. I went into a shop, ask the man if he talked English, and he answered: "I was born in Boston." He had been 13 years in Tahiti; said he was never going to leave, that they were the only people who knew how to live; that American life was artificial. "In America," he continued, "you get up in a hurry, you eat your breakfast in a hurry and go to the office in a hurry; you eat your lunch in a hurry, you go home in a hurry, then you hurry to a theatre or a movie show and at last hurry to bed. If you don't hurry, hurry, hurry all the time, you are not in the swim. Here, in Tahiti we do what we want to today and put the rest off till tomorrow or next year, and that's real life." Now, this fellow was not joking—he meant it, and there was a lot to it. Like all Bostonians, on the top of the counter he had a large Webster's Dictionary and he was enjoying himself, true Bostonian fashion, in looking up words between customers. I imagined I was the only customer that day.

I thought I would like to visit the hospital, so I presented a letter of introduction to His Honor, the Mayor. He talks excellent English and saw service in France during the war. He was most apologetic that I could not be admitted to the hospital. He said, "Our hospital is a very primitive affair; it might be called archaic; all we do is emergency work. It is under the control of the Government and I am almost ashamed as a physician, to be associated with it, but it is part of my official duties. Some years ago, one of your American confreres came to Tahiti and inspected the hospital and on his return to the States he wrote a very severe criticism about it; this reached the eye of the Governor, since which time nobody is admitted without a special permit from the Government. You know," he continued, "we are very poor here in Tahiti and when there is a little money to be expended, other services have the priority."

The influence of disease on a population is shown by the fact that when, in 1919, influenza came to Tahiti, 40 per cent. of the native population died. This is partly accounted for by the fact that the Tahitians now wear clothes like Europeans, which causes them to perspire and catch cold easily, while before the coming of the white man, they used to wear nothing but a loin cloth, but kept their bodies covered with grease. The white man has done nothing to the natives but bring him all kinds of pests and disease, and I was told that syphilis is very prevalent on the island. The white man brought rats and also brought a bird called the Deacon Bird, which has driven all the native birds away.

On September 22d, 1914, the German cruisers "Scharnhorst" and "Gneisenau" bombarded Tahiti, there being a small French gunboat in the harbor at the time. The whole population fled to the hills. There was some excuse for this bombardment because the French Governor, as soon as the German vessels were sighted, caused all the coal and stores to be burned; this made the Germans so mad that they threw a lot of shells into this very primitive town, not a very heroic procedure; however, it probably can be forgiven when we realize that a few weeks later both the German ships were sunk off the Falklands.

RAROTONGA. — Two days after leaving Tahiti we arrived at Rarotonga. The harbor is very poor in comparison to that of Tahiti; you have to go ashore in a small lighter. The general configuration of the island is very similar to that of Tahiti, a mass of rock thrown up out of the sea, with a fringe of arable land around the water's edge. It is only about 25 miles around and there are no roads whatever into the interior.

I had a very pleasant two days with the medical officers in charge of the island. The island is under the administration of New Zealand who send out to it two medical officers to take charge of the entire group of Cook Islands; there being 14 in the group and these men visit every one of them at least once a year. The nearest island to Rarotonga is 140 miles away and the further nearly 700; communication between the islands is by means of small sailing vessels. I was appalled at the heroism of both Dr. Trotter and his assistant, Dr. McKenzie, a young man only out of Guy's three years ago. These men go from one island to the other in a trading vessel; the trader will leave them on an island—they

will call a council of the native chiefs who will then bring to them their sick; they will investigate the sanitary conditions and take the next trader back to Rarotonga. If a trader does not come along, they wait until one does.

New Zealand is doing a wonderful work in Rarotonga. The island belongs to the natives; no white man can buy a foot of land; if a native wants to lease his land to a white man he has got to have the consent of the government. No Chinaman or Japanese are allowed there, and while this is a debatable question, it is keeping the island for the natives, while Tabiti is gradually passing under the control of the Chinese, they being in charge of all the stores and now in possession of a good deal of the land.

Rarotonga has a population of 3,000 natives and about 150 whites. It has a well-equipped hospital and they are doing highly scientific work. Any white man going to Rarotonga receives excellent medical care, for which he is not allowed to pay as the New Zealand Government employ both physicians to give their whole time and refuse to allow them to accept any other compensation. The hospital is modern in every respect. It is presided over by a white female superintendent, assisted by native nurses. Dr. McKenzie has equipped in his own home a very good laboratory, and the New Zealand Government has promised to send a complete laboratory equipment to the hospital by next November. The whole air of the island is that of cleanliness, order and good administration. Again, I was impressed with the efficiency of the medical men. These two men have demonstrated that hookworm is prevalent in Rarotonga. They estimate that 80 per cent. of the natives are infected by it, but it is in a much milder type than is the case in our Southern States and in South America.

When I return I am going to try and see if the Rockefeller Institute will not interest itself in the hookworm problem in Rarotonga, for it could be easily stamped out by the expenditure of some money. A disease that is common in Rarotonga is what is called "Yaws." It is a chronic skin disease caused by *spirochaeta pertenuis* or *pallidula*. It is very closely allied to syphilis and causes a chronic skin lesion. Dr. Jonathan Hutchinson, Sr., years ago taught that Yaws was syphilis modified by the tropics; this before we had any bacteriological knowledge of our syphilis, and this has been partially substantiated in modern

times, for while it is not syphilis it is very closely allied to it. Dr. McKenzie told me that one injection of salvarsan permanently cured the disease. Elephantiasis is also common; it is conveyed by mosquitoes. The influence of immunity or the lack of immunity among primitive peoples to the diseases that are so common with us is shown by what happened in Fiji about 30 years ago; the Fiji Islands are also under the control of the British and their last King, Cakabon, was pensioned by the British. Two of his grandchildren were sent to Sydney to be educated, and while at school there contracted measles. They immediately returned to Fiji and were allowed to land. The gravity of the situation was not realized. From them measles rapidly spread over the island, causing a death-rate of 33 per cent. of the total population.

In Rarotonga they are studying the mosquito question with a most startling result; we ought to know all about mosquitoes in New Jersey, but the mosquitoes in the South Sea Islands are a different kind and there is very little malaria. Although I expected to be over-run with mosquitoes, I found no nets in the medical officer's house; he kept the mosquitoes down simply by taking care that no stagnant water was allowed to accumulate around his house, and he told me a most interesting thing—in one of the bays in Rarotonga there are two islands, side by side, only 300 feet apart; one had mosquitoes and the other none. Investigation showed that there were a few cocoanut trees on one of the islands and none on the other. The island with the cocoanut trees had mosquitoes while the other was free. His explanation was that the rats ate the cocoanuts and the cocoanut shell accumulated enough water to form a breeding place for the mosquito, as the mosquito in Rarotonga cannot develop in either wind or sun; it has to have still water protected from both wind and sun. Speaking of cocoanuts, they are God's own boon to the islands of the Pacific. Of course they are wild and from a few trees a native family may live without work all their days. It furnishes them meat, drink, garments, habitation and household utensils. There is a native proverb that says "When God made the cocoanut the fish were not near," meaning, that if he had put in the fish he would have put in everything that could be desired in this world.

The Maoris of Rarotonga were the original settlers of New Zealand. They came

cross 1,800 miles of open sea in canoes and there are still about 50,000 in New Zealand, so it is especially appropriate that the Rarotonga native should receive the fair treatment from the New Zealand Government that it has. In the early days of New Zealand, 1805, Great Britain sent out Sir George Grey as the Governor of New Zealand, and he being a scholarly man as well as a very wise one, acquired a very intimate knowledge of their language, which he published in a book after he returned to England, giving their traditions and that of their priests. It is most enhancing reading; they read like our fairy tales, chiefly being, however, tales of heroism as well as fairies. I had a wrong impression about the South Sea Islanders; I regarded them chiefly as cannibals; it is true that they were cannibals and that they practised infanticide, but they are a most heroic, courageous, intelligent and I think, hard-working race when you consider that they don't have no work; but when necessary they work harder than any white man I ever saw, for I saw a gang of natives work continuously 17 hours loading the ship with oranges as Rarotonga sent 16,000 cases of oranges to New Zealand by our ship, and all these had to be carried in lighters from the shore.

The great export from both Tahiti and Rarotonga is what is called copra, that is dried coconut. This is used in the manufacture of all good soaps. The copra from Tahiti goes chiefly to the United States and that from Rarotonga goes to England.

One of the fairy tales of the Maori has to do with the formation of the earth; they believe that the heaven and the earth were originally united and that it was their early gods who succeeded in separating them, and they think that the mist that rises from the earth is the sighing of the earth for her lover the heavens, while the dewdrops are sent from heaven to his love the earth.

New Zealand prohibits the sale of any alcohol to the natives, although apparently the whites can get all they want. Both in Tahiti and Rarotonga there are a number of Nature Men and they are more or less of interest to both the visitor as well as the native. There is one that poses as a successor to Christ and is supposed to be able to walk on the water. Some years ago some of the natives became skeptical and asked for some proof of his ability to perform this feat. He solemnly gathered all of his followers and gravely enquired of them: "Do you all from your hearts believe that I can walk on that water," point-

ing to a large body of water. "We do," was the response. "Then there is no necessity for me to do it," he calmly responded and walked back to his hut.

We reached Wellington on August 4th after a very stormy trip from Rarotonga. It is mid-winter here, cold, no snow, but driving rains. The change of coming from the tropics into such cold weather has been very trying. The New Zealanders do not know what we mean by warm houses. They make up for it by wearing rather heavy woollen underwear, a thing that in Eastern America is becoming very scarce.

I have had two delightful days visiting the different members of the profession, and have been entertained most royally. The superintendent of the Wellington Hospital showed me every nook and cranny of the institution. It is to be noted that the Wellington Hospital compares favorably with any in the world, as far as the care of its patients are concerned. Last year the medical superintendent spent several months visiting our large cities and studying hospital problems, and on his return made a report of American medical hospitals, which is published by the public printer, and is very interesting reading from an American standpoint.

The Wellington Hospital is gradually being rebuilt and renovated and they plan to spend a million dollars on construction and improvement during the next few years, and I was pleased to see that New Zealand is looking to America for the improvement in hospital management and construction. The hospital is supported from the public purse and has the weakness that so many state and municipal hospitals have (from the standpoint of the profession) that they do not refuse to admit patients who are in position to pay for the medical services. However, the patients if they are able, are requested to pay for their hospital board.

As far as I can make out there is no investigation of the financial status of the patient in relation to compensation for medical services, all that apply are admitted if they need medical care. They have a well-equipped x-ray department and laboratory. But I feel sure that the profession will have to demand that the hospital shall not enter into competition by treating people who should pay proper fees for their medical services.

The profession in New Zealand is very well organized, but as is general, they have not as yet seen the necessity of demanding

protection against the irregular practitioner. Eighty-five per cent. of all the members of the profession belong to the British Medical Association, which has a branch here in New Zealand. The Minister of Health is also a member of the association. It is unfortunate, however, that he has never been in active practice. How similar things are throughout the world. How few men in medical positions have the proper contact with the profession that is so desirable, and this I think because the profession has not interested itself in public affairs as it should, and consequently medical men who are really not interested in medicine are apt to be appointed and the profession is not properly represented, but it is something to have a Minister of Health, as they have in New Zealand, for in America there is no one who is responsible for the health activities of the government. These activities being distributed apparently indiscriminately between the different departments at Washington.

In far off New Zealand the Chiropractor is also present. Beginning with two men in each town, the number has gradually increased, and the methods are exactly the same as that in America—Commercial Advertising. Yesterday's New Zealand Times contained a half-page advertisement by a firm of Chiropractors which must have cost somewhere between 250 and 500 dollars. The advertisement was a long statement by clergymen, a great part of which was a hidden attack on the ability of the medical profession. Of course, it is simply a part of their general publicity scheme of denunciation and self-exploitation. One thing that impressed me is that up to the present time these men have not dared to call themselves doctors, simply calling themselves Chiropractors. This is certainly a great deal better than we have it in New Jersey, for there by their stealing the term "doctor" a layman cannot tell that they have not had a proper education.

Abscess of the Spleen.—Dr. Smits of Holland, has observed some rare types of abscess of the spleen. As a rule abscesses of the spleen are of secondary origin and result from: 1. an infarct or metastasis; 2. a traumatism, or 3. an abscess in an adjacent organ. Smits observed four cases, one of which was a complication of endocarditis, another of typhoid, a third of puerperal infection, and the fourth of gonorrheal salpingitis. He saw two other cases which followed an abscess in an adjacent organ; one a perinephritic abscess; another case, an amebic abscess.

County Medical Society Report

MORRIS COUNTY.

Dr. Marcus A. Curry, Reporter.

The annual meeting of the Morris County Medical Society was held on the evening of September 9th, at the New Jersey State Hospital at Morris Plains, by invitation of Superintendent Dr. Curry, with the cordial approval of the Board of Managers of the institution.

President Dr. Hampton presided over the meeting, which, applying a reasonable discount for the hardship of weather and road conditions, was rather well attended by thirty members. Among the guests were the more recent appointees to the hospital medical staff and Secretary Frank W. Pinneo of the Essex County Medical Society; also Mr. W. R. Hale, representing the Wood Brook Farms, Metuchen, New Jersey, producers of certified milk.

Routine business was transacted, during which Treasurer Reed manifested the stability of the Society's finances, creditable alike to his genial persuasiveness and ready reaction of the members, by announcing no members in arrears and over a thousand dollars clear balance after paying running expenses and \$500 donated to the Morris County Home for Children at Parsippany, which was voted at the previous meeting.

Dr. Louis K. Henschel, for many years a member, and now permanently located in practice in New York City, forwarded his resignation which, in the circumstances, was accepted.

Proposals were made by Dr. Lathrop of two honorary members, and Dr. Kice and Dr. Collins each proposed a regular member, which will be voted upon at the December meeting.

This being the annual meeting the election of officers and delegates for the ensuing year was in order. The recommendations of the executive committee were submitted and there being no other nominations, in each instance the secretary was duly instructed to cast a ballot, which resulted in the unanimous election of the following officers and delegates:

President, William A. McMurtrie, Morristown; vice-president, Francis H. Glazebrook, Morristown; secretary, Henry W. Kice, Wharton; treasurer, F. Grendon Reed, Morristown; reporter, Marcus A. Curry, Greystone Park.

Executive Committee.—Dr. Samuel C. Haven, Morristown; Dr. William F. Costello, Dover; Dr. George H. Lathrop, Morristown; officers ex-officio members.

Delegates.—Dr. August L. Baker, Dover; Dr. Frank L. Bird, Netcong; Dr. Edward P. Cooper, Parsippany. Alternate Delegates.—Dr. Aldo V. Coultas, Madison; Dr. Marcus A. Curry, Greystone Park; Dr. George S. De Groot, Mendham.

Secretary Pinneo of the Essex County Society was invited to address the meeting and gave an effective discourse on the potential power of the medical profession to advance its interests and the interests of the general public, by concerted and cohesive action, after which he read, by request, an interesting and illuminating paper on the subject of "Certified Milk."

Retiring President Dr. Hampton addressed

he members and guests, saying: "We have finished another year and I shall summarize the year's work in a few words. We have progressed, we have added more members to the roll and now have seventy-one members. Every member on the roll, up to tonight, is paid up clear. During the year we have donated \$500 to a good cause, to the Children's Home at Parsippany, and still have over \$1,000 in the treasury to be used for emergencies. During the year the meetings have been very well attended and it seems to me more interest has been taken; but the most striking feature of all the meetings during the year was our March meeting at Dover, when we had a symposium, when each member of the society got up and read a paper on pneumonia. I believe that was the best meeting of the year. I think we ought to continue that practice and set aside one meeting a year for the physicians of the society to get up papers and read them and in that way create more interest. I suggest that we continue that program and suggest that the next March meeting be given up to papers by members of the Society, not confined to any particular branch, but anything pathological, medical, surgical, and bringing out anything that is new and anything that will be of profit to members of the Society."

President Hampton then spoke on a few symptoms which he had gotten together on encephalitis lethargica, stating that already a number of patients have reached the State Hospital at Morris Plains, suffering from post-infectious encephalitic conditions, insanity and psychotic conditions, directly due to the infection. Dr. Hampton gave an interesting discourse on the history of the disease from its origin in India in 1916-1917 and presented three of the patients at present under care and treatment at the Morris Plains institution. The members entered into the discussion, and were free to approach and ask questions of the patients, all of which was of much medical interest.

The formal meeting being concluded, the members and guests were invited to an uncommonly appetizing supper provided at the hospital, novel feature of which was the serving of certified milk from the Wood Brook Farms of Metuchen, which well stood the test of all that was previously said about it.

It was voted to follow the custom of former years and hold the December meeting at Morristown.

A New Chair at Jefferson Medical College.

In recognition of the far-reaching developments of bronchoscopy in the diagnosis and treatment of diseases of the lungs and of esophagoscopy and gastroscopy in the diagnosis and treatment of diseases of the esophagus and stomach, the Board of Trustees and faculty of the Jefferson Medical College have created a new chair, to be known as the Department of Bronchoscopy and Esophagoscopy. Dr. Chevalier Jackson, formerly Professor of Laryngology in the Jefferson, has been elected to the Professorship of the new department. Dr. Fielding O. Lewis has been elected to fill the chair of Laryngology vacated by Dr. Jackson.

Public Health Items.

PROTECTION AGAINST SMALLPOX.

The managers of the Bergen County Hospital have sent out the following appeal to Boards of Education, Boards of Health, Physicians and Nurses:

"Five cases of smallpox having recently developed within the County of Bergen, the attention of the public should be directed to the large proportion of our population who have not been vaccinated against smallpox.

Smallpox is an acute contagious disease, that is in many instances attended by a very high mortality rate.

Vaccination is inoculation against smallpox, and a successful vaccination prevents this disease.

Following the devastating epidemics of smallpox during and after Civil War, practically every person was vaccinated, and for many years following that period of almost universal vaccination there was comparative freedom from smallpox. In recent years, because of the infrequency of smallpox due to extensive vaccination, the general fear of the disease has vanished, and has been supplanted by the impression that smallpox has been conquered. **This is a false sense of security, and the liability is increasing at an enormous rate, due to this large group of unvaccinated.**

Vaccination gives a long term of immunity, and in most cases lasts a lifetime, but after a number of years **re-vaccination** is advisable. Properly administered and with physician's instructions carefully followed, vaccination is a safe procedure. Boards of Education, Boards of Health, Physicians and Nurses can exert the greatest influence in a campaign for general vaccination.

To promote the interests of our rapidly growing county, will you enlist your services in this movement for disease prevention?

BOARD OF MANAGERS,

Joseph R. Morrow, M. D., Sup't."

The board has also had printed a placard in large type and has had it posted in all available public places, calling attention to the importance of vaccination and re-vaccination.

Declaration of Geneva.

The Save the Children Fund International Union has drawn up and published in 36 languages the following declaration:

By the present Declaration of the Rights of the Child, commonly known as the "Declaration of Geneva," men and women of all nations, recognizing that mankind owes to the child the best that it has to give, declare and accept it as their duty that, beyond and above all considerations of race, nationality or creed:

I. THE CHILD must be given the means requisite for its normal development, both materially and spiritually.

II. THE CHILD that is hungry must be fed; the child that is sick must be nursed; the child that is backward must be helped; the delinquent child must be reclaimed, and the orphan and the waif must be sheltered and succoured.

III. THE CHILD must be the first to receive relief in times of distress.

IV. THE CHILD must be put in a position

to earn a livelihood and must be protected against every form of exploitation.

V. **THE CHILD** must be brought up in the consciousness that its talents must be devoted to the service of its fellow-men.

Permissive and Mandatory Health Laws.—

For the purpose of public health advancement, a permissive law is superior to a mandatory one; just as an affirmative law is superior to a prohibitory one, if we view the shaping and promotion of health legislation as an educational process. It is far easier to lead the public to a course of public policy than it is to drive them, even though the former procedure may consume a longer period of time. The use of a mandatory law can be justified only when there is a clear and unmistakable expression of public opinion in favor of drastic dealing with a given situation.—R. G. Paterson: Hosp. Soc. Serv.

New Epidemic in Japan.—A recent dispatch from Tokio says: Several of the most eminent physicians have left hurriedly for the Western provinces where a new epidemic, resembling spinal meningitis, is reported to be raging, causing nearly 900 deaths in recent weeks. The local physicians call it "narcoleptic meningitis." The victims undergo the usual symptoms of spinal meningitis and then fall into a comatose state, remaining so until death. The mortality is at the rate of sixty-five per cent. The provinces affected are Kagawa, Tokushima, Okayama and Toyma, on the island of Shikoku. Dispatches from the provinces indicate that the epidemic has spread throughout Western Hondo, the main island of Japan, as well as throughout Shikoku.

Light, Sight and Safety.

Faulty lighting and poor eyesight "are today the major factors in one out of every eight accidents," it is asserted by R. E. Simpson, engineer of the Travelers Insurance Company, Hartford, Conn., in a report to the Eye Sight Conservation Council of America, which is carrying on a nation-wide campaign for better vision in education and industry. Fully 66 per cent. of American workers have defects of vision, according to the report.

In pre-historic times, Mr. Simpson points out, the safety of both man and beast depended upon acuteness of vision. The only natural agent producing glare was the sun, but with the introduction of gas and electricity as illuminating agents the eye has been forced to contend with new perils.

"Accidents do not simply happen more or less haphazardly, but are caused—there is an underlying reason back of every accident," the report continues.

"There is indisputable evidence that the momentary and temporary blindness caused by workmen having unshaded lamps close to their eyes and in the direct line of their vision is directly responsible for many industrial accidents. There is also evidence of accidents because of this same kind of blindness due to the specular reflection—more commonly known as glare—from brightly polished material within the range of vision. These and many other evils of illumination prevalent a decade ago were reflected in the accident rate

to the extent of being decidedly contributory factors in one out of every four accidents."

Does Faith Healing Heal?—Under the above caption The Survey of July 15, report on a study of alleged faith-healing "cures"—a study made by a committee composed of 1 ministers, 8 physicians, 3 university professors, and 1 lawyer. This committee was appointed by the General Ministerial Association of Vancouver "to inquire in to the authenticity of the alleged cures and present the conclusions which they drew from the facts. According to The Survey:

The names of 350 persons, all alleged "cures," were obtained. All of these cases were investigated; the list of their ailments sounds like the sections of a medical encyclopedia. They range from cancer to bronchitis, pyorrhea to epilepsy, elephantiasis to neurasthenia, idiocy to ingrown toe-nail—to name only eight of more than sixty specified diseases and deformities. Of the whole group of patients, five had been so distinctly benefited that at the end of six months they could be regarded honestly as cures; 38 showed specific or general improvement; 212 showed no change, though at the time of anointing they had been declared cured; 17 cases were distinctly worse, 39 had died; and five of the persons anointed, and four members of the families had become insane.

New Mercurical Formula in Septic Conditions.—Application of this formula discovered by physicians of the Johns Hopkins Medical School and generally administered in cases of kidney and septic inflammation, has apparently effected a cure in two cases of malignant heart disease, usually fatal, according to an announcement at St. Francis Hospital, Hartford, Conn. The patients, one a boy and another a man of twenty-five, were suffering with temperatures and with little chance of recovery the doctor stated. After the remedy was applied temperature returned to normal and both patients are believed to be out of danger.

In New Haven, Conn., this new preparation has not yet proved successful as had been hoped in the case of Judge James H. Webb of the State superior court, critically ill with septicæmia, according to Dr. George H. Joslin, who is attending the jurist. The treatment was administered for about a week and immediately afterwards the patient showed improvement, Dr. Joslin said, but this has not been maintained. Judge Webb was reported to be in a critical condition.

Calcium Treatment of Tuberculosis.—Hartwich-Borrmann combines calcium with potassium to dehydrate the organism. The prescription is calcii chloridi, 30 parts; potassi acetatis, 60 parts; aquae, 285 parts. Sig. One teaspoon in a glass of warm water, half hour before breakfast. In exudates, good results were obtained after giving up to six teaspoons daily. This treatment has been applied in appropriate cases during the last two years among the 600 inmates of the Lyste Sanatorium in Norway. A number of typical cases are described in detail to illustrate the special advantages in cases with profuse moist rales. The calcium can be given by the

mouth or rectum, subcutaneously or by the vein, and in various forms. A dry cough is no contraindication for calcium treatment, but the doses should be smaller.

Miscellaneous Items

3. Proofs of the Constitutional Nature of Cancer.—L. Duncan Bulkley points out that during the past one hundred years Abernethy, Walshe, Sir Astley Cooper, Sir James Paget, Dr. Williard Parker, Dr. Forbes Ross, Robert Bell, and others have expressed the belief that cancer is a constitutional disease. The facts which point unerringly to the proof of the constitutional nature of cancer are presented in the following statement:

1. **Laboratory Findings:** Negative—Cancer is not parasitic; cancer is not contagious or infectious; no cause for cancer has been found. Positive—Cancer cells are but altered normal cells; feeding experiments show a possible control of cancer growth.

2. **Statistical Evidence:** Contrast of death rate since 1900 between cancer and tuberculosis; steady increase of cancer deaths under active surgery, x-ray and radium.

3. **Biochemical Evidence:** Blood changes in early and late cancer; metabolic changes in the system before and after the development of the local cancerous lesion.

4. **Clinical Evidences:** Opinion of many celebrated surgeons during the last one hundred years to the present time; spontaneous cures of cancer well authenticated; dozens of hundreds of attested cases of benefit or cure of cancer by other than local measures, in this and other countries.

Most of the items in the above statement are thoroughly known and accepted. Looked at in its entirety, the total evidence of the constitutional nature of cancer is fairly convincing.

Suppurative Otitis Media Treated by Zinc Ionization.—Dr. T. B. Jobson, England, in The British Journal reports that during the past year 50 patients were referred for treatment by ionization. They included 57 suppurating ears, and of these 45 were treated by ionization. In 29 of these the otorrhoea rapidly ceased; 2 relapsed after a few weeks, 13 were not cured, and of 3 the result is not known. This gives a percentage cure of 60.

Of those not cured 6 were cases of cholesteatoma and 2 were old mastoid operation cases. Neither of these classes is quite a fair test of this method of treatment. Omitting these eight failures the percentage cure works out at 80. By cure is meant complete cessation of discharge. The advantage of treatment by ionization are: It will cure any case of otorrhoea which is curable by drops, and in one-hundredth part of the time, thus saving an enormous amount of the patient's, doctor's, and hospital's time. It will cure a large number of cases which do not mend with ordinary antiseptic treatment.

Treatment of Simple Goiter.—Perhaps the most satisfactory plan of medical treatment is to administer from 2 to 4 gm. of desiccated thyroid in 0.2 gm. doses daily, and, after allow-

ing an interval of two weeks without treatment, to saturate the thyroid with iodine by giving 30 c.c. of syrup of hydriodic acid or its equivalent in iodine from 1 to 2 c.c. doses daily. This treatment may be repeated every third or sixth month. The maximum reduction will occur in from six to twelve months.—T. Clark: Pub. Health Rep.

Premature Cesarean Section.—Dr. J. Caraven, in Gynecologic et Obstet, Paris, reports a rare case of uterus bicornis. The young healthy mother wanted to have a living child, but a few days after the seventh month of the pregnancy a serious hemorrhage developed, due to premature detachment of the placenta. Since intervention was urgent, regular cesarean section was performed. Both mother and child were saved and left the hospital twenty days after the operation. The child, after having passed through a period of gastro-intestinal derangement, is now thriving well.

A New Remedy for Syphilis and Sleeping Sickness.—The laboratory of the Rockefeller Institute which has already supplied to the world so much valuable information, has recently sent out another important communication giving an account of a new and most important contribution to therapeutics. The new drug is known as tryparsamide. This remedy has been found a most efficient means of destroying the animal parasites which infect the blood and tissues in sleeping sickness and in syphilis. Similar remedies which have been heretofore used with more or less success in the treatment of the affections have proved inefficient in certain classes of cases particularly in the more advanced cases in which the parasites have found their way into the central nervous system and other parts which have proved to be inaccessible to 606 and other remedies of a similar character. The new remedy, tryparsamide, proves, however, to be possessed of remarkable penetrating powers. Fortunately, tryparsamide is, while more efficient in the class of cases not reached by other remedies, at the same time less toxic and better tolerated by the tissues. This is highly important, for it is not to be forgotten that arsenic is a highly toxic substance and that drugs capable of destroying parasites in the body cannot be innocuous to the cells of the body itself.

Syphilitic Heart Disease.—Dr. Jacobæus of Copenhagen, regards it as very important to combat the asystolia first, then start with mercury, and continue with mild arsenphenamin treatment unless sure that cicatricial lesions are not involved. By the time there are murmurs and other symptoms in syphilitic or rheumatic heart disease or tabes, the lesions are usually beyond the reach of arsenphenamin and salicylic acid. In a case described, the syphilis had been treated with inunctions of arsen, and ten years later aortitis developed, with dyspnea, palpitations and dizziness. The man, aged 41, was given 2.45 gm. of arsenphenamin in the course of six months (six injections). Then he developed diarrhea, intractable vomiting, enlargement of the liver and jaundice, with fatal collapse the ninth day. In another case, a large aneurysm developed above the right clavicle in the course

of a month, thirteen years after papules in the mouth had been the only manifestation of syphilis. Under a single injection of arsenphenamin, the aneurysm began to subside, and entirely disappeared under two or three more.

Treatment of Psoriasis.—Dr. E. A. Purdum, J. Ark. Med. Soc., in treating cases of psoriasis has obtained uniformly good results with injections of 15 or 20 grains of sodium salicylate intravenously every three to five days. While the drug is being administered, particularly if a small vein is being used, there may be some pain extending up the vein. This may usually be controlled by giving the injection more slowly. In patients of more advanced age it is best not to exceed a dosage of 20 grains at any one injection.

In the psoriasis cases of long standing the writer has been able to obtain better results with this method along with external applications of a 20 per cent. mixture of chrysophanic acid and petrolatum. The ointment is applied to the patches twice daily with a stiff tooth brush. The patients are kept in bed—a full length union suit is worn and the eyes are bandaged at night. This routine is continued on an average of seven days. The patient should live largely on green vegetables, fruits and other articles having a high caloric value but low protein value.

Injuries of the Hands and Feet.—All contused injuries to hands or feet should be x-rayed if there is the slightest doubt as to the extent of the injury. The number of unsuspected fractures of phalanges, carpals and tarsals is very large. Unrecognized and improperly treated fractures of these small bones not infrequently result in arthritis, absorption of bone and new bone formation where it is harmful, so that months of disability and often a permanently injured member results.—W. L. Finton in the Michigan State Society Jour.

Roentgen Diagnosis.—The clinician should retain his seat at the head of the council table. He should know the limitations of roentgenology and the man who is using it, for men vary in skill in different parts of the same field. He should weave the laboratory reports and his own knowledge into a coherent, reasonable, logical diagnosis, one that he would accept if he himself were the patient.—Russell D. Carman in New York Med. Jour.

Half the misery in this world comes for want of courage to speak and to hear the truth.—Harriet Beecher Stowe.

Deaths.

ENGLISH.—At New Brunswick, N. J., September 19, 1924, Dr. David Combs English in his 83rd year. Further report on page 325.

LOWEREE.—At Newark, N. J., September 23, 1924, Dr. Thomas W. Loweree, in his eighty-third year.

Sanatorium.

Bonnie Burn Sanatorium.

Dr. John E. Runnels, superintendent, reports as follows: On July 31st, there were 260 patients in the Sanatorium, 148 males and 112 females. This included 98 children in the Preventorium. Since the last report, 29 patients have been admitted, 11 males and 18 females. Seven of these admissions went to the Preventorium. The admissions are classified as follows: Pretubercular, 7; incipient, 3; moderately advanced, 8; far advanced, 11; total, 29. The largest number of patients present at any time during the month has been 267. Smallest number, 252. Present August 29th, 252. This number includes 83 children in the Preventorium and 82 out of the county patients.

Personal Notes

Dr. Walter A. Reiter of Summit has been making a tour of the Mid-West cities.

Dr. H. J. Wallhauser of Newark has returned from a month of motoring through interesting sections of Canada and the New England States. Mrs. Wallhauser made the trip with him. They visited the Rangeley Lakes, the White Mountain region, the Belgrade Lakes in Maine, Portland and other points, having good weather and good roads most of the time.

Dr. Hugh M. Hart, the Newark Fire Department surgeon of 300 Mt. Prospect Avenue, Newark, is making his round to his fire fighting patients these days on a pair of crutches as a result of an injury to one of his legs while spending his vacation on the Jersey shore.

Dr. Jotham C. Johnson and family will return to their home on Chestnut Street, Newark, October 1, after a stay of several months at their summer home at Sodus Point, N. Y.

Dr. and Mrs. Herbert West Foster of 10 The Crescent, Montclair, returned recently from Boothbay Harbor, Me., where they have been spending several weeks.

Dr. and Mrs. Samuel C. Haven, Morristown, have returned from camp at South Milford, Nova Scotia.

Dr. Sara D. Smalley of 530 Clifton Avenue, Newark, returned last week from a trip through Vermont and New Hampshire.

Dr. and Mrs. J. Henry Clark of Walnut Street, Newark, returned Wednesday after a two months' stay at Oguquit, Me.

Dr. Elbert S. Sherman and family of 671 Broad Street, Newark, have closed their summer house at Point Pleasant and returned to their home in Newark.

Dr. W. R. Ward of Chancellor Avenue, Newark, has just completed a short vacation in Newfoundland and Nova Scotia.

Continued on page XXIV.

On the main line of the Lehigh Valley and the Central Railroad of New Jersey. Three and one-half hours from Philadelphia. Four hours from New York. Eight hours from Buffalo. One hour from Wilkes-Barre.

SUNNYREST SANATORIUM

White Haven, Pa.

A Private Sanatorium for Incipient Cases of Tuberculosis

LOCATED high in the Blue Mountains of Pennsylvania, 1,300 feet above sea level, you have at your very doorstep the best of the delightful scenery of a region noted for its natural beauty and healthful climate.

There are both cottages and individual bungalows. All rooms are private.

For patients on exercise, there is a centrally-located dining-room. Bed patients are served by competent maids. There is an experienced *chef* with a natural appreciation for good and wholesome food.

There are modern facilities for the most advanced methods of treatment. There are specially trained graduate nurses always in attendance.

Patients with a natural appreciation for comfort, service and amusement, will find Sunnyrest a delightful place. For those on exercise, there is a newly finished miniature outdoor golf course with all the thrills and hazards of a full-length course. There are wide

verandas and comfortable chairs. There are charming walks through woods of spruce and pine and oak.

Patients are under the direct medical supervision of the following well-known physicians: Drs. H. R. M. Landis, Joseph Walsh, Frank A. Craig, Isadore Kaufman, Elmer H. Funk, all of Philadelphia, and Dr. Alex. Armstrong of White Haven.

Terms for private room in Cottages: \$30.00, \$32.50, \$35.00 and \$40.00 per week. Terms for individual bungalows with private bath and dressing-room: \$45.00, \$50.00, and \$60.00 per week. This includes everything but Medical Fees.

Reservations are now being made. For particulars, address:

IVAN F. GOODRICH, Gen'l Manager

Sunnyrest Sanatorium (East Side) White Haven, Pa

Orange Publishing Company

Printers, Publishers
and Stationers

14 So. Day Street,
Orange, N. J.

Mutual Pharmaceutical Company

INCORPORATED

MANUFACTURING PHARMACEUTISTS

OWNED AND OPERATED
BY AND FOR PHYSICIANS

*ucts and Money Saved on
Hundreds of Physicians Testify
to the Reliability of our Prod-
Purchases. :- :- :-*

LET US ADD YOUR NAME TO OUR
MAILING LIST

Syracuse

New York

PERSONAL NOTES.

Continued from page 336

Dr. and Mrs. Edward L. Burns of 535 Mt. Prospect Avenue, Newark, have returned after spending more than two months traveling abroad. They visited France, Belgium, Holland, Switzerland and Italy. Their daughter Mrs. Gladys Burns Stranahan, who accompanied them, remained to spend several months studying music at Fontainebleau School. Mrs. Stranahan has sung this summer in concerts abroad and, during a visit of the Queen of Spain to the Fontainebleau School, was the one chosen to sing before her. She sang at a concert in Paris on September 20.

Mrs. Frances Drummond Stanwood, wife of Dr. Robert G. Stanwood, and for twenty-five years a resident of Newark, died suddenly on September 15th at the home of her daughter, Mrs. J. W. Till, 99 Park Street, East Orange.

Dr. and Mrs. Charles F. Baker of 198 Clinton Avenue, Newark, have returned from an automobile trip in the White Mountains.

Dr. James T. Hanan of 11 The Crescent, Montclair, returned home recently after attending surgical clinics in Cleveland, O.; Rochester, Minn., and Detroit, Miss.

Dr. Hugh F. Cook and family of Scotland Road, South Orange, have returned from the Poconos, where they spent several weeks.

Dr. and Mrs. William Buermann and family of Newark, having spent the summer at their country residence in Awosting, N. J., have returned to their home on Lincoln Park.

Dr. and Mrs. James H. Brothers and family of Newark have returned from Belmar, where they spent the summer.

Dr. Julius Sobin of 77 Thirteenth Avenue, Newark, returned recently from a two-week automobile trip through New York State and Canada. Mrs. Sobin accompanied him.

Dr. and Mrs. J. Harry McCroskery and family of North Arlington Avenue, East Orange, have returned from Cape Cod, where they spent six weeks.

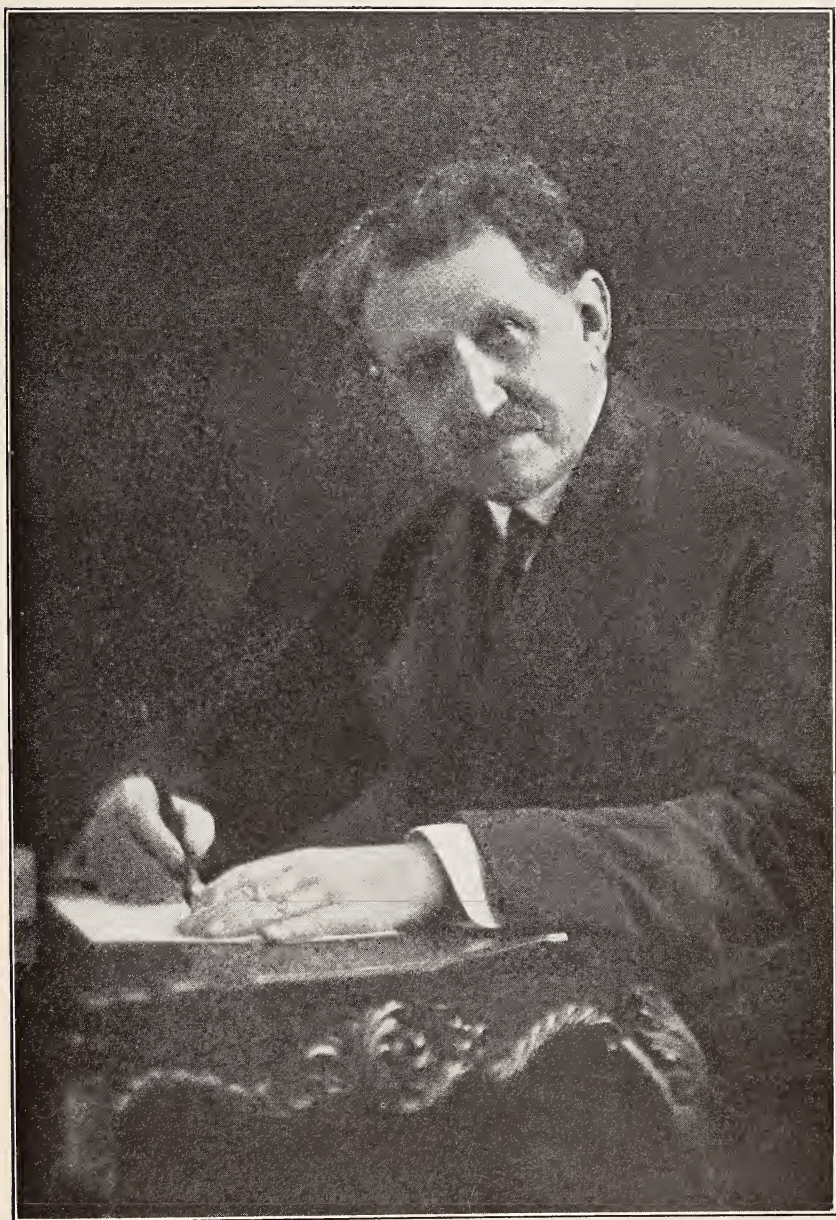
Leaving Lake Placid a few days ago en route to their home at 235 Grafton Avenue, Newark, Dr. and Mrs. Clarence V. R. Bumstead have returned from their summer vacation.

Dr. F. M. Hoffman, New Brunswick, and wife enjoyed a vacation at Ashbury Park and Manasquan.

Dr. and Mrs. Richard J. Brown and their sons, Richard Jr. and Edwin, of 211 Roseville Avenue, Newark, have returned from their summer home, Hemlock Lodge, at Ridgefield, Conn. They will continue to spend week-ends there until November.

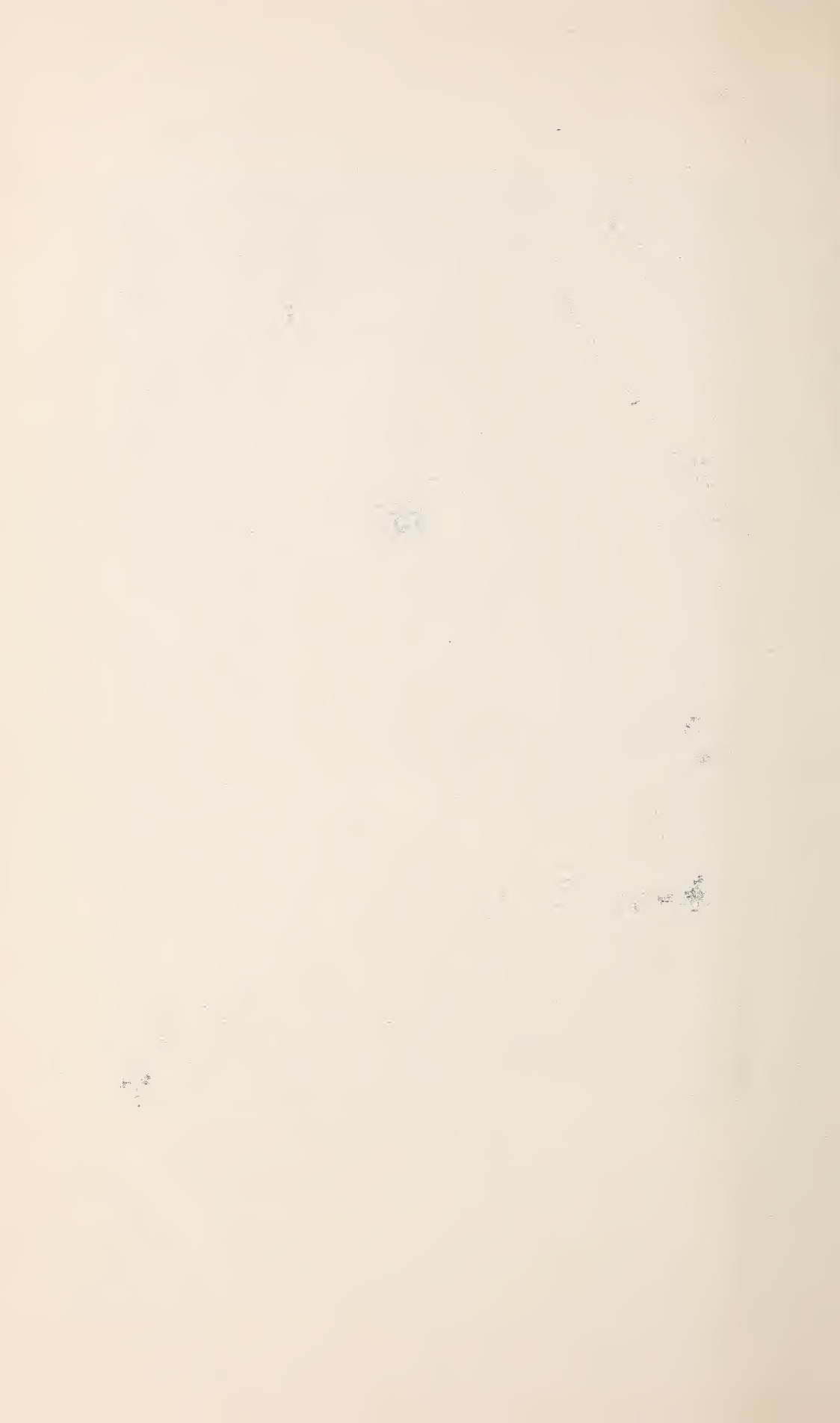
Another Newark doctor, who has just returned to his city home, is Dr. Harold A. Murray of 624 Mt. Prospect Avenue. Dr. and Mrs. Murray came up from the shore recently. They had a cottage at Avon for the summer.

Dr. and Mrs. Lloyd Stickles of 49 Parkhurst Street, Newark, have gone to Palm Beach, Fla., to spend their vacation. They expect to return in October.



WELLS P. EAGLETON, M. D.
NEWARK, N. J.

*President of the Medical Society of New Jersey
from June 23rd, 1923, to June 7th, 1924.*



Journal of The Medical Society of New Jersey

Published on
the First Day of Every Month



Under the Direction
of the Committee on Publication

Vol. XXI, No. 11 ORANGE, N. J., NOVEMBER, 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

THE ADDRESS OF THE PRESIDENT AND THE REPORT OF THE WELFARE COM- MITTEE OF THE MEDICAL SOCIETY OF NEW JERSEY, OF WHICH HE WAS CHAIRMAN

By Wells P. Eagleton, M. D.

Delivered at 158th Annual Meeting of the
Society at Atlantic City, N. J.,
June 6th, 1924.

The Medical Society of New Jersey was organized in 1766—ten years before the signing of the Declaration of Independence,—with the objects, "*mutual improvement, the advancement of the profession, the promotion of the public good*, and every gentleman of the province was invited to become a member." How has it fulfilled these objects?

Mutual improvement? — The scientific progress in the cure and diagnosis of disease has been and still is the chief object of our existence. Every year—every day, we strive to improve scientifically.

The promotion of the public good?—No one, not even our enemies deny us this. Ours is the only profession which tries to eliminate itself—by preventing people from needing our services. Preventive medicine is the medicine of today.

But the *advancement of the profession*? Mark the phrase—not the advancement of the individual, but *advancement of the profession*. An individual advances spiritually, culturally and financially; a profession advances ethically, economically and politically, and I am sorry to say that, in my opinion, while ethical standards have remained high, they are today not as high as those of 153 years ago. For when the practitioner of medicine was an aristocrat—aristocrat by both education and sentiment. They were, as a

class, highly cultured men. This was especially manifested among legislators, where a large number of physicians were always to be found, because as aristocrats they regarded *government* as the highest type of service. One of the signers of the Declaration of Independence was a practising physician.

Today, to enter politics many think is to descend. And because of neglect to play our proper part, the profession of medicine has not advanced—politically. Today, unless I read the signs of times mistakenly, if we do not correct this defect it is bound to have a disastrous effect on the rank and file of medical men.

For if the economic and ethical relationships between the public and the individual doctor undergo the same degree of change in the next ten years that has occurred since the signing of the Armistice—a change brought about by the unfair and dishonest competition which the doctor today is compelled to meet,—unfair and dishonest because the State rightly demands of the medical man that he be required to have a high degree of technical education in schools and hospitals and forbidden to exploit himself by commercial advertising, while the State at the same time is admitting to practice uneducated and consequently medically incompetent men who, by virtue of the State's authority or indifference, are allowed not only to openly advertise themselves and thus deceive the public as qualified to practice healing—their claims to the title of "Doctor" having often been obtained after a so-called medical course of from three weeks to six months, or a so-called post-graduate course after as little as three days; but also to systematically publish untrue and misleading statements as to the general competence of the medical men to treat diseases; if, I say, this unfair and dishonest competition is al-

lowed to increase unchecked to the same degree during the next ten years as it has during the last eight, then before the next decade has passed the economic struggle for existence by the rank and file of the members of the medical profession may be so keen that only men of means will be tempted to enter the ranks. A result that, although disastrous to the profession itself, would be a thousand-fold more disastrous to the nation as a whole. Up to 1924, as far as I know, New Jersey has been the only State that has had the vision and the wisdom to see that something definite and systematic must be done, to further the interests of the profession as a whole, and through it to give proper protection to the individual doctor and to preserve the esteem in which the profession is held by the public, which has been shaken by false and dishonest propaganda.

The first charter of our Society was obtained in 1790—seven years after the termination of the American Revolution, and expired by limitation in 1815. In 1866, on the one hundredth anniversary of the Society, it petitioned that it was “desirous of surrendering all of its special privileges and pecuniary immunities.” Think of it!—applying to the legislature to give up advantages! Such an action is almost unique in legislative annals. With every industry asking for greater and greater protection, the Medical Society of New Jersey petitioned to “surrender all its special privileges and pecuniary immunities.” The charter of 1866 continued to give its component societies authority to confer the degree of M.D., which was the only right of importance preserved from the old original charter. For since its formation the component district societies of the State Medical Society had possessed the right to bestow the title of Doctor of Medicine on such of its citizens whose learning, character and conduct made them worthy to bear such a title before the public.

In the early part of this century the last of its original great privileges was voluntarily surrendered. A greater piece of folly was never perpetrated. The result is that this year, 1924, 400 physicians visited Trenton in an effort to *obtain some legal protection* from the abuse of the term “doctor,” the control of which the medical profession had carelessly thrown away less than a quarter of a century before. This was largely because the physicians of that day—engaged in the scientific study of disease—in their busy daily practice,—failed to see

that economic and industrial conditions might change, and that change would call for protection of learning, just as today American labor is demanding and obtaining protection against unrestricted immigration. The same as the foreign-born, physicians of New York State have obtained protection against the competition of doctors from across the seas by demanding that they become American citizens before a license to practice is granted them. France has been compelled practically to refuse to grant licenses to Russian physicians. We here in New Jersey have not felt any pinch as yet, but I am told that 160 foreign physicians of one nationality alone are planning to enter New Jersey this year, while the number of German and Austrian physicians that are already here is not negligible. All these New Jersey could easily absorb, were it not for the unfair competition of the cults, licensed and unlicensed, who today number many hundred in New Jersey.

On my way home from Trenton a gentleman who has recently come to these shores, asked me:

“Why is it that we, in England, are not bothered by uneducated practitioners? For while the professional competition for existence in the British Isles is fierce and acute, it is not in the form of competition from without; it is because of the number of physicians.”

And my answer was: “The University of London, the University of Edinburgh, the Archbishop of Canterbury, the University of Glasgow, and the University of Oxford had the right given them years and years ago, to confer the degree of “Doctor of Medicine.” If these had been so foolish as to surrender their trust to any agency not wholly educational as did the medical profession in New Jersey, or if they had been so careless of the trust as to allow commercial corporations to bestow the title of “Doctor” without proper educational qualification, as has the American medical profession, then the medical profession in England would be having today the same trouble.”

The jealousy with which the medical profession of England guards against any abuse of the title of “Doctor of Medicine” was recently illustrated. During the war, a “bone-setter” rendered efficient and valuable service to many of the soldiers. After the Armistice, the Government, wishing to reward him, asked that he be “qualified” as a regular member of the medical profession, to which the reply was made “that it

was impossible as he had never had the educational qualifications demanded, but as his work had undoubtedly made him worthy of recognition, it was suggested by the profession that the Government "make him a baronet"—and a "Sir Knight" he is, but not a doctor.

What is the history of medical legislation? Prior to 1890, the New Jersey law required that for a man to practice medicine, he must file with the clerk of the county, a diploma showing him to be a graduate of a medical school of good standing. The clerk then registered him as a physician. Although there was a lack of uniformity in the curriculum and graduation requirements, all members of the medical profession in 1890 were graduates of regular medical colleges, which at that time demanded a course of two years.

With the desire to have the State demand the highest degree of medical knowledge then obtainable, members of the medical profession itself (chief among whom was Dr. James Wrightson), caused to be enacted in 1890, the "Medical Practice Act," with special educational requirements, to be followed by an examination by the Board of Medical Examiners. All these requirements have gradually been increased until today a man must be continuously in school or hospital for eleven years after he has left grammar school and seven years after his graduation from a high school.

Between 1908 and 1911 there had come into this State, from failure to enforce our medical practice act through indifference of the profession and the Board of Medical Examiners, (who in former years regarded themselves as a licensing and not a prosecuting body), about 300 osteopaths, who demanded recognition. Many of these men were without medical training—some were graduates of correspondence schools. However, through political influence, which they had carefully fostered for years, we were compelled to accept a bill which gave them recognition and which "whitewashed" all who had been practicing for one year, by the State, but demanded that those who were to come later were to have some education. We were compelled to accept this "whitewash," because only a handful of physicians paid the slightest attention to the problem. For once in 1911, as chairman of the Legislative Committee in Essex County, I issued a call, asking all physicians to go to Trenton. At the time appointed I found a solitary companion awaiting me at the station.

In 1915 about 95 more osteopaths were given licenses by a special exemption act. In 1920 the chiros passed their bill giving them a separate Board of Chiropractic Examiners. This board had authority to license whomsoever they pleased without any specified educational requirements whatsoever. At that time the medical profession was held in such disrespect politically that although it requested a hearing on the bill, none was granted. The bill passed the Legislature, was signed by the Governor, and became a law. Within four months the Board of Chiropractic Examiners licensed nearly 500 chiropractors to practise in this State.

Do you know that after the repeal of the original chiropractic law an examination of the records in the State House failed to discover a single piece of paper or record to show on what qualifications or examination these chiropractors were licensed. The records of the Chiropractic Board have apparently either been lost, destroyed or stolen.

The following year, the medical profession in its wrath, caused the repeal of this bit of legislation and re-established New Jersey's educational standards in the "Limited Practice Law of 1921," which the Legislature of 1923, however again tore down, giving those chiros who had failed to obtain or had been refused a license by the old Board of Chiropractic Examiners an opportunity to license without requiring of them the education called for by the "Limited Practice Act." Against this act our Welfare Committee objected in the Legislature, and after its passage, filed a brief of protest with the Governor, calling attention to the dangers of the amendment. The wisdom and truth of which protest has since been demonstrated by a decision of the Supreme Court against the Board of Medical Examiners, who apparently did not appreciate the far-reaching clauses of the amendment.

Now do you think that all this *special* legislation to obtain license to practice without adequate training has been accidental or peculiar to New Jersey? I tell you no. All these legislative moves were largely dictated by instructions from without. Those in the State were told that they must operate politically to obtain special legislative favors. And the medical profession must not blame them if they are given educational exemptions by legislation from the profession's indifference to the demands of our form of government, viz.: that everyone should be interested in his government,

as he helps to make it, for it is our duty to see that the public is protected by demanding adequate learning of all who practice healing.

Now, the licensed osteopaths and chiropractors are here—nearly 1,000 of them, while of the unlicensed healers of all kinds it is reported there are twice the number. The answer is, chiefly, publicity. This is an age of publicity. Today the man who is acclaimed by the public is not the man who is doing good work, but the man who advertises himself in and out of season; *he* is the man. But our ethics forbid publicity to the physician, and rightly so. The osteopaths recognized this and commercialize it. One of the chief courses in the osteopathic colleges in 1910 (when they were inspected by the Carnegie Foundation) was in advertising. But, to do them justice, they claimed simply that they had better results than physicians in their so-called "mechanical treatment" of disease.

But the chiropractors really voiced the insincere sentiments of the times, for their chief point in their public advertisement is not only their ability to cure disease by so-called "natural means," but also to claim the failure of all other forms of treatment.

Do you know that all the legislators in 1921 received a public circular stating that the medical men lost one out of every 31 cases of influenza, the osteopaths one out of 158, but the chiropractors only lost one out of 850. The manifest falsehood of the statement that we lost one in 31 could not be given sufficient prominence as the medical profession has no machinery for publically calling attention to this glaring misstatement, and the daily press, to whom the chiropractors paid large amounts of money for advertising, were naturally friendly to them in many instances, and the press, if once humbugged on a "story" of news, regards it as good policy to forget an error instead of being decent enough to publish a denial.

Another factor that has helped their publicity of misrepresentation is that many private patients of today are on the same social and cultural plane as the charity patients before 1914. All hospitals are complaining of the over-running of their wards by private patients with the lack of refinement and with that inquisitiveness which was formerly found among only the charity patients. This because of the redistribution of wealth that accompanied the war, for while great groups of people are now well off financially, their manners and habits have still remained low.

What has been the effect of this on the public? Great hoards of people believe in cures because they are not in a position to know the facts of the case, and have read their cures and our failures, both grossly exaggerated. Some of the public, from this public reiteration, has gradually come to believe the untrue statements that medical men as a class are incompetent.

If you will read the Literary Digest for September 12th, 1923, you will find under the heading "*What People Think of Doctors*," a survey of the attitude of over six thousand people in Chicago, in different walks of life, which shows that 93 per cent. of all these 6,000 do not go to a regular physician unless severely ill. Why? Because they have not that confidence in the profession to which it is entitled by its learning and service, partly because of the persistent attack on its ability; for the great mass of these people had no real or imagined grievance against any member of the profession.

The medical profession have been between two unjust forms of competition; first publicity or advertising, which is and always will be refused the profession, and licensing by the State without adequate medical training.

These are the conditions. What has the Welfare Committee of the Medical Society of New Jersey done about it? In 1921, in resentment at the affront by the Legislature to the medical profession in refusing it a hearing, the Welfare Committee was created and money appropriated for its legitimate expenses. The following year, we succeeded in abolishing the obnoxious law and passing the "limited practice" act, which compels all who would practice healing to have at least a decent education and to pass an examination. We passed the limited practice act because all the physicians of the State were interested, one thousand physicians visiting Trenton at one time. We told the legislators that we would definitely try to defeat those that persisted in upholding a low educational standard.

If one thousand had visited Trenton this year and stayed until the adjournment the "Doctor" bill would today be a law. Following 1921, in 1922, we tried to defeat fifteen legislators and succeeded better than any expectation could have foreseen, as seven of the fifteen "stayed at home." An Assemblyman in Union County was defeated by a majority of over two thousand, while the previous year he had had a ma-

jority of over eight thousand. And one Assemblywoman of Essex County was also defeated by the efforts of Essex County Society, assisted by the women, who did not like her opposition to the bill for the control of venereal disease. Largely because of the success of the profession in Union County, in 1922 we passed the medical amendment to the Workmen's Compensation Law, and in 1923 succeeded in having the Department of Labor, (under whose direction the law was enforced), adopt the principle that in its administration physicians' bills should be reviewed by a Board of Physicians:—one doctor being nominated by the State Medical Society, one by the manufacturers and one by the Department of Labor—the three agencies interested—all doctors, not laymen or insurance companies as formerly.

This was a great victory. Some have said that our Medical Amendment to the Workmen's Compensation Act has done the doctors little good, but let me tell you that the cost to the insurance companies for doctors' bills amounts to 32% of the total amount expended, while formerly it was but 15%—an added revenue to the physicians of 112%. This means many hundreds of thousands of dollars more are now being paid to the physicians of the State for industrial work than formerly. In other words, it means that you are now paid \$212 for the same amount of work that formerly you were paid but \$100 for; and it means, more important still, that your bill is reviewed by a Board of Physicians who decide whether it is just and equitable—not by an insurance company or a lay-director.

This, as far as I know, is the first successful effort to do something economically for each individual doctor by the *Medical Profession itself*.

This year opened very auspiciously, Governor Silzer realizing that the Workingmen's Compensation Act is fundamentally a medical measure, offered the Commissionership of Labor to Dr. Andrew McBride, who, after refusing it, was induced to make the sacrifice, simply from a sense of duty and service to his State and generation. Governor Silzer also agreed to accept a scheme creating a Board of Medical Advisors to help him in matters of public health. This was prepared by your committee and adopted by the Governor and is now in operation. It reads as follows:

"There shall be formed a so-called Medical Advisory Board consisting of five physicians appointed by the Governor from a

list submitted by the Medical Society of the State of New Jersey, whose duty shall be to render assistance to his Excellency or to the Department of Institutions and Agencies, or any Department of the State's Government in matters pertaining to health policies (to the health of the State or of its wards), and to disseminate such knowledge among the medical profession with the purpose of placing the technical and scientific knowledge of the profession at the disposal of the State and interesting the medical profession in public health problems."

If the members of this board fail to make themselves so indispensable to the administration that at the expiration of Governor Silzer's term of office, the next Governor does not feel the need of such assistance, then a great opportunity to be of real service to the State and the profession, both politically and economically, has been lost. Your Welfare Committee has created the opportunity, it is up to the members of the Board to improve it for the benefit of the whole profession and the State.

Committee's Policy.—*The Welfare Committee has had a definite program for the past three years. Every move has been in accordance with that program. This program has two planks: first, it has aimed to increase the respect in which the profession as a whole is held by the community. This it tried to accomplish by introduction of legislation for the solution of the problems which are distinctly medical. For your committee believes that one of the best forms of publicity the medical profession can have is to be obtained by advocating health legislation.*

In pursuit of its policy it has tried to interest all physicians in public affairs, as it believes that "physicians through their training, through their ethical standards, through their years of service, are the only ones who are competent to properly guide the State and the nation in matters of health." *The second plank in the policy has been to protect the interests of the medical profession as a whole and of each individual capable and honorable man in it.*

Believing in the necessity of honest group publicity we have conducted in a very limited way a campaign of publicity. In this a conscious effort has been made to cause the people of the State to talk about "the Doctors." Before the formation of the Welfare Committee, legislators and the public spoke of "my doctor, or Dr. Smith, or Dr. Jones"—but as the result of this effort it is now frequent to hear it said, "This is

the doctors' bill or *the doctors* are in favor of this or that." When we first went to Trenton we were treated with amused respect. I frequently heard it stated that we were "idealists but impractical—we did not know the game."

That is, to a certain extent, true—your committee lost one of its bills by not knowing the game as played. But what is needed more than any other thing is conviction in the inherent strength of principles and of square dealing, and these will win in Trenton if persistently played. Truth, honor and principles lose many battles, but no wars.

How did the committee work?—It met at regular intervals from September 15th to January 1st, and then at least once weekly during the legislative session.

How did your committee prepare its legislation?—It called conferences of medical men and studied the problem. It obtained data of what had been done by other States. It then told its views to a lawyer who drew up a bill on these lines. The bill was then discussed, section by section, by the committee and in more than one instance a second bill was drawn by another lawyer, and once a third bill. The committee then put them all together, taking out of each what it regarded as best. If all legislation had been drawn as carefully as all our legislation, there would be few poor laws on the statute books.

It was failure to follow this policy in the original Senate Bill 159, from delay of an outside agency, and then our own haste (as the bill had to be in before midnight), that was the prime cause of its failure.

"Marriage Certificate" and "Sterilization" Bills.—Following the policy of increasing the respect in which the profession is held, we this year introduced two bills. One, the "Marriage Certificate" Bill which aimed to prevent the spread of venereal disease. For say what we will, this "scourge" is still with us as is shown by the report of the Public Health Committee of the New York Academy of Medicine, which states that "a survey of some of the maternity hospitals shows that syphilis is present in from 2.9% to 10% of all the women seeking admission for child-birth."

The other, the "Sterilization" Bill strove to give the Commissioner of Institutions and Agencies the right to unsex "the feeble-minded, the chronically insane, and the habitual criminal of mental deficiency, when such feeble-mindedness, insanity or mental deficiency may be transmitted to their off-

spring." That this procedure is necessary no one in possession of the facts will deny.

The Medical Society of New Jersey, through its Welfare Committee, presented the State with a *preventive program*. The existing machinery of the State was used so as not to add a greater burden to the taxpayers, who are annually being asked for more and more millions for the support of "wards of the State"—thus creating a veritable "aristocracy of the incompetents—with total neglect of all *prevention*,—the obviously necessary thing.

Neither of these passed, but they were the result of a careful scientific study by a trained body of men to solve State problems and I tell you that ten years from today those measures, largely as we formed them, will be in operation in the majority of States in America.

Why have our efforts been frustrated in getting these bills adopted? Largely because of the doctors. I say it with all deliberation, that they are not as loyal to themselves or to each other as they should be. In 1922 a body of twenty-seven doctors in Essex County signed a petition which was exactly in conflict with the action of their own county society. They did not know what they were doing, but it caused the defeat of medical legislation in 1922. This year, whenever I have heard opposition to the marriage act, or the sterilization bill, it has been because some doctor, instead of coming to the Welfare Committee with his objection or expressing it before his county society at its meeting, has gone to the legislators and told them his objections, and this but too often without much knowledge of the problem or the solution offered.

"Lye Bill."—Your committee gave its support to a "Lye" Bill compelling a "poison" label to be attached to packages containing caustics, etc., which had been prepared by a committee of the A. M. A., of which Dr. Orton was chairman, in an effort to prevent accidental strictures of the esophagus. It passed and is now a law.

Expert Medical Testimony.—All members of the profession have long realized that the wide discrepancies in expert medical testimony, so frequent in damage suits, are a disgrace, and frequently have given rise to the charge that the doctor's viewpoint is largely influenced by his own financial interest, thus detracting from the respect in which the profession as a whole is considered by the public. I placed this matter before the officers of the New Jersey Bar Association, who, realizing its importance to

the legal fraternity, appointed a special committee. At the joint meeting of the committees of the Bar Association and the State Medical Society, the following scheme was submitted by me, based largely upon the plan now in operation in England's Compensation cases:

"That an effort be made at the next session of the legislature to so alter the legal procedure in cases involving expert medical testimony, that the court be given authority to appoint a special medical expert for each case, such expert to be selected by the court, and whose bill for service be vouched for by the court. That such an expert being a part of the court, should occupy a position beside or below the Judge, showing him to be a part of the court as far as medical matters were concerned, being as it were a medical adviser to the court itself."

The reasons for such a scheme are that the opinion of a medical man as a representative of the court would carry great weight, while not interfering with the right of both the plaintiff and the defendant to have as many experts as they deem necessary. The opinions of a medical man so selected by the court, and consequently not financially interested in either side, would undoubtedly discourage extreme partizan testimony, which at present is but too frequently obvious at trials.

This met with the unanimous approval of the special committee of the Bar Association who decided to report it to their society at its annual meeting, with a recommendation that as its members are to visit England this summer, they be instructed to investigate the matter. It is to be hoped that on their return, details will be perfected by the committees so that a bill may be introduced at the next Legislature, formulated and endorsed by both the N. J. Bar Association and the Medical Society of N. J.

It is important that this matter receive the close attention and support of the whole profession during the next few months.

WORK FOR THE PROFESSION.

Workingmen's Compensation.—A conference of all medical men of the State Society who were known to be interested in the problem, and representatives of the Department of Labor, was called with the object of discussing the advisability of legislation "giving the injured working man the right to choose his own physician." As a result of the conference the following circular was prepared and sent:

"To Employers and Insurance Carriers and Any Others Concerned in the Workmen's Compensation Law of New Jersey:

"Inasmuch as the operation of this Law has occasioned some misunderstanding about its provisions, the Medical Society of the State of New Jersey, courteously makes this address in order to facilitate harmonious action on the part of the parties concerned, viz.: the injured, or sick employee; the physician, or surgeon, who treats him; the employer or insurance carrier.

"Chapter 245, Laws of 1922, provides that upon due notice the employer 'shall furnish to the injured workman such medical and surgical and other treatment and hospital services as shall be necessary to cure or relieve the workman of the effects of the injury and restore the function of the injured organ or member where such restoration is possible,' provided that when the services in excess of \$50.00 are thought to be necessary, said medical service in excess of \$50.00 will be obtained by application to and approval of the Compensation Bureau and also by a request upon the employer to furnish them except under the exceptional circumstances mentioned in the statute.

"It is obviously to the advantage of all that the injured workman should have the same right to choose his physician, or surgeon, as under the ordinary circumstances of sickness or injury, provided that the employer's interest shall be safeguarded to the extent that the services shall be competent and efficient, and honorably rendered, in order that the restoration shall be as complete and prompt as possible and the charges reasonable and just.

"The spirit of this address is to facilitate harmonious understanding and to urge the employers and carriers to adopt the course suggested in order to disrupt as little as possible the natural relationship between families and their physicians, or surgeons; this is the procedure which is now generally followed by the majority of manufacturers and insurance carriers.

"The medical profession of the State are unanimous in their opinion that the principle that the injured workman should have the right to choose his own physician is correct, but on account of the complexity of the interests, it has refrained from seeking legislation which would make it mandatory. Hence this courteous appeal.

"The medical profession is unanimously against contract practice, and the employment of physicians from outside the State of New Jersey by manufacturers or insurance carriers, as not conducive to efficient and prompt treatment or that understanding between employer and workman and the medical profession which is desirable."

This was signed by 20 members of the Welfare Committee as representing 14 different component societies of the Medical Society of New Jersey, and given the widest publicity obtainable.

Damage Suits Against Physicians.—The number of malpractice suits has greatly increased during the past few years, fostered largely by a class of lawyers, many with

the ethical standards of the "ambulance chaser." One of their chief tools has been threats to use the public press, which has frequently been used as a weapon for intimidating physicians.

Realizing that the better part of the press of the State at least did not fully comprehend the extent of their exploitation, the following request was sent to every paper published in New Jersey.

Statement to the Public Press

The Medical Society of New Jersey endeavors to protect its members from the unjust practice of individuals who have instituted "strike" malpractice damage suits against physicians. In no instance has the Medical Society protected, or will it protect, any physician who has been guilty of negligence, dishonesty or incompetence, much less violation of law. In some instances during the past few years suits have been brought against members of this society where there has not been the remotest chance of obtaining a verdict. These suits have been instituted by individuals, with the assistance of those members of the bar who place pecuniary advantage above ethical consideration, with the idea that the physician, to avoid publicity of such action, would settle out of court.

This method too frequently has been simply a disguised form of blackmail, to check which the Medical Society of New Jersey organized a Defense Council, who after hearing the physician's side of the case, if they regard him guiltless, order the case defended. In the past two years out of suits aggregating \$400,000, not a single dollar has been collected by law. In every case that has been defended by the State Society the verdict has been in favor of the physician.

On the face of this record we are asking the press of the State to co-operate with us to help to stamp out the unfair practice of "strike" suits. The medical profession requests the press to refuse to publish an account of any suit until its actual trial in the courts. Whatever verdict is rendered by court or jury, the facts should be published, but "news stories" of suits which are simply "strikes" are detrimental to the morals of the community as well as to the physicians attacked, as those who institute "strike" suits use news publicity, although at the time they may know that the physician is absolutely innocent of wrong; they seek a financial settlement without carrying the case to trial. Without the publicity from the newspapers, there would be very few "strike" suits.

"The Passaic Daily News" has announced a policy of publishing nothing about a damage suit against a physician until the suit is terminated in court. This policy is one which the medical profession would respectfully request be adopted by all newspapers, and is asking for your co-operation by adopting a similar policy for your paper in the interest of public morality, as well as for the protection of the members of the medical profession. After consideration will you kindly inform us whether your paper will adopt such a policy?

The effect has been most gratifying as in several instances some of the press has since refused to accept "stories" of alleged malpractice against physicians, while a few of the papers have expressed a willingness to adopt the policy suggested.

It is most desirable that this be made the first step in an active campaign in the interest of the whole profession to be carried on in the press in the near future. It should be one of the duties of a full-time executive secretary.

Legislation Affecting the Profession as a Whole.—As the result of the scandal in an adjacent State in which men were licensed whose diploma had been obtained by fraud, the New Jersey Board of Medical Examiners had prepared a bill giving it "supervision over all colleges and schools teaching healing." The measure as originally drafted contained no standard to be demanded, leaving this to the decision of the Board. Your Welfare Committee, in conference with the Board, insisted that the standard of "Class A Medical College as now required by the Board" should be incorporated and thus made mandatory.

The Board having accepted this alteration, the bill received the full support of your committee. It passed the Senate, but an effort was made to kill it in the House on the last day of the session. It was only saved by the political ability and quick-wittedness of Dr. Quigley. It was promptly signed by the Governor and is now a law, becoming effective September 1st. The vote as recorded on this most important law which will henceforth assure a good equipment and a high educational standard from all schools or colleges of healing operating in New Jersey, is as follows:

In the Senate.

Affirmative—Borton, Davis, Harrison, Larson, Mathis, Pierson, Reeves, Richards, Roberts, Stevens, Woodruff—11.

Negative—None.

In the House.

Affirmative—Barrison, Barkman, Rostock, Botti, Camby, Campbell, J. M.; Carling, Carty, Clift, Compton, Cook, Corio, Crawford, Delaney, De Lorenzo, De Voe, Finn, Greiner, Hanson, Hoffman, Hurd, Kipsey, Marshall, Pascoe, Renner, Robinson, Sharkey, Siracusa, Thompson, J. J.; Thompson, L. W.; Vanderbilt, Vaughan, Welsh, Zlonczewski—34.

Negative—Anderson, Beardsley, Black, Blizzard, Campbell, J. G.; Chandless, Dowling, *Fort, Howe, Lindeman, Muir, Osborne, Pine, Sexsmith, Stewart, Williams—16.

*Miss Fort writes me that she voted in the affirmative although she is recorded in the negative, this being, as she writes, an instance of the desirability of altering the voting sys-

tem of the Legislature which she has been advocating.

Two "Chiro Repealers" aimed at the Chiro amendment of 1923, (one of which annulled the whole amendment, and the other revoking that portion exempting from any examinations, veterans of the World War); both failed.

The profession should insist that the whole amendment of 1923 be repealed. If the Chiro or any other cult wants to practise healing they should be compelled to meet the requirements of "The Limited Practice Act," passing an examination in the fundamental branches, anatomy, physiology, etc., underlying all healing.

A "Chiro Bill" giving veterans of the Spanish-American war a license without examination, a "Naturapathy," and an "Annual Registration for Physicians" bills, all opposed by your committee, died in committee.

A bill "to pay a medical expert out of the costs of the trial" in compensation cases, the same as legal counsel, is now provided, which was favored by your committee, passed the Assembly but died in a committee of the Senate.

Effort to Protect the Term "Doctor."—The advisability of preventing the unqualified from deceiving the public by advertising as a "Doctor," had been repeatedly presented to the Welfare Committee and a plan was under consideration by your chairman who, (after obtaining a list of the degrees, both academic and honorary, conferred by the institutions of learning in New Jersey and its vicinity) was in favor of legislation preventing only those not holding such degrees from using the term Doctor in public advertising, on signs, etc., the validity of the institution conferring the degree to be decided by the Commissioner of Education.

Governor Silzer in his annual message said:

Welfare Labor and Sweat Shop Evils.

"During the past year a committee of physicians was appointed to aid the various departments in their work and to advise them with respect to matters concerning public health and to aid in bringing about co-operation between departments and to avoid overlapping and friction.

"The Executive had the pleasure of appointing to this committee a number of prominent physicians who were willing to undertake this public service. They have already given valuable service and have made helpful suggestions."

"One of the matters.....relates to the granting of licenses to persons who are to practice a profession in any way concerned with the giving of relief to, or curing the ills

of the human body. The attention of the Legislature is directed to this subject, with the suggestion that the laws, where necessary, should be strengthened so that the proper board may have sufficient power to act, when the occasion arises, in the protection of the life and health of the people of the State.

"It is also suggested that the title 'Doctor' should not be permitted to be used except by those who are licensed to practice medicine, surgery and dentistry in connection with the human body (including, of course, purely honorary degrees.)"

These bold and wise words decided your committee to immediately have such a clause incorporated into the Medical Practice Act, the wording of which leaves no doubt that such was its original intent.

Coming as the suggestion did, from the Governor of the State to the people and its legislature, it was deemed advisable that the amendment be prepared by a Department of the State. This matter was consequently submitted to the officer then in charge of the Department. This was a fatal mistake, as nearly two weeks of the most precious time was lost and the proposed amendment did not reach your committee until but few hours before the termination of the time set by the legislature for the introduction of bills. It was read aloud to the committee assembled in an ante-room of the State House at Trenton, and as it sounded as if it would stop the abuse of "Doctor," it was introduced with our endorsement. A few days later, when a copy of the printed bill was carefully read, it was appreciated that its wording made it capable of a most drastic application, then apparently manifest. This, of course, was far from the desire. On realizing this, your committee immediately repudiated the bill and had prepared bills out of which was constructed its substitute, the so-called "Doctors' Bill" (Senate Substitute No. 159), which aimed "to preserve the title of Doctor for those on whom a degree had been properly conferred or recognized by the State." It prevented no one from publicly using "Doctor" in relation to healing who was in the least, legally or morally, entitled so to do. Drs. Quigley, Pinneo and your President all gave the largest part of a week in its preparation and attempted enactment.

As was to be expected, it awakened a storm of protest among the 2,700 men who are today using the term doctor without a proper degree, but it was heartily endorsed by the whole medical profession, 400 of whom attended a "hearing" in Trenton in

answer to a general call to the whole profession by your committee.

The bill passed the Senate 15 to 0, the following being recorded as voting for it: Agans, Barber, Blackwell, Bright, Davis, Harrison, Larson, Pierson, Reeves, Richards, Simpson, Stevens, Whitney, Woodruff—15.

However, before it reached the desk of the President of the Senate for his endorsement prior to going to the House, it "disappeared." At last the President of the Senate demanded that the bill be "found," which was done on the day previous to the adjournment of the Legislature. It was sent to the House on the last day of the session, but kept in the Committee of Public Health, the chairman of that committee being antagonistic, and all efforts to have it reported failed, although several physicians had previously been repeatedly assured that the bill would be reported immediately after it reached this committee.

There is no doubt in the minds of your committee that had it reached the floor of the House it would have passed. The forces causing its disappearance knew their job, for had it reached the House one day earlier it could have been brought to the floor by the so-called rule of 15. As it was, two members of the Committee of Public Health agreed to sign for its release if we could get a third. This bill is of the greatest importance to the whole profession. It should be re-introduced next session and the whole weight of the profession should be behind it. It will tremendously facilitate the prosecutions of illegal practitioners of all kinds and will do more to protect the profession and the State from incompetents than any previous legislation.

One of the factors in the defeat of the Doctors' Bill was the "Chiropodists' Bill" which gave great surgical privileges to chiropodists. It was opposed by your committee, but after passing was vetoed by the Governor in the following words:

"Too much care cannot be exercised in throwing protection around those who need medical care and attention. I do not think that this bill gives our people that protection.

"Under this bill, chiropodists (even those with limited education and experience), may perform minor operations and may amputate anything less than the entire human foot. They may administer local anesthetics and do other things which should only be practiced by the most skillful persons.

"They may use the word 'doctor,' and may become qualified by examination before a board of two chiropodists.

"There is already too much suffering and injury from the treatment of the human body by those unskilled and ignorant.....

"Our every effort should be to tighten the restrictions, rather than to release them.

"There is no reason why chiropody should be extended to the performance of surgical operations, with all the dangers incident thereto.

"I, therefore, disapprove this bill."

In spite of the manifest wisdom of the Governor's veto, so powerful was the influence behind this measure that on the Legislature reconvening a few days later, an effort was made to pass it over his veto which, fortunately, also failed.

Those recorded as voting to over-ride the Governor's veto being:

Beardsley, Black, Blizzard, Campbell, J. G.; Campbell, J. M.; Chandless, Corio, De Lorenzo, Dowling, Eaton, Fort, Hershfield, Hoffman, Howe, Hughes, Hurd, Kenworthy, Mills, Muir, Osborne, Powell, Sexsmith, Siracusa, Sonn, Stevens, Stratton, Thompson, J. J.; Thompson, J. W.,—28.

While the following are recorded as voting to sustain the Governor's action:

Anderson, Barrison, Barkman, Botti, Camby, Carty, Clift, Compton, Crawford, Delaney, De Voe, Evans, Finn, Kipsey, Lindeman, Marshall, Zlonczewski—17.

Expenditures.—Your committee has expended a little less than \$5,000 during the past year, a detailed report of which has been submitted to the Board of Trustees and the Treasurer of the Society. All the books of the committee are open to inspection and criticism or suggestions by any member of the profession will be welcomed. The personal expenses of the committee have been borne by themselves during the entire year.

Acknowledgements.—The medical profession is indebted to Governor Silzer for his wise and manly stand in medical matters during the past year. Every physician in this State should realize that Governor Silzer is the first Governor in recent years who has stood firmly by the profession, realizing that it represents the health and the good of the community and not alone its own personal interest.

Drs. Lippincott of Camden, Hunter of Gloucester, Detrecht of Washington and Muchler of Morris not only were in constant contact with their legislators, but repeatedly came long distances to attend the meetings of the committee. Dr. Costill is to be thanked for getting the President of the Senate to insist that the "Doctors' Bill be found." But especially do I wish to express my appreciation to Dr. Quigley and Dr. Pinneo for their self-sacrificing devotion to the cause of the profession during this year. Both these men gave unstintingly of their time and thought—often at great personal sacrifice. The medical profession of New Jersey owes them much.

A Retrospect.—What has been accom-

plished from so much labor? Has the result warranted the labor? When we consider that in 1920, the Assembly refused to grant the profession a hearing and that the State then licensed nearly 500 men to practice healing without demanding of them prescribed educational qualifications; and that since the entrance of the profession into politics only 34 have obtained any exemptions, and these only because they were practicing in our State before the passage of the limited practice act; when we consider that in the formation of the original Workmen's Compensation law—largely a medical measure—physicians were not consulted, while today the opinion of the profession is sought in all health measures; when we consider that formerly physicians were but seldom added to State Boards, while today it is much more frequent—my answer is that all this labor has been well rewarded. But a much greater reward has been vouchsafed.

Three years ago, as your Third Vice-President, I addressed you:

"We live in a democracy. Democracy is the rule of the majority, but the majority is mediocre; consequently it has been said—and with truth—that a democracy is the rule of the mediocre. But the members of the medical profession are not mediocre. By their years of training, by their ethical standards, by the culture which has become theirs from years of research and thought, they are qualified to understand human needs: but in the pursuit of a scientific understanding of disease, in the very wonder and love of medicine they have, as a class, been led away from their larger duties as public citizens. Physicians must realize that they alone are qualified to supply to the nation that *expert information* which it must have."

Since then as the result of my experience in studying the workings of our Government, I am more and more convinced that if democracy is to live and advance, it is up to the profession to at least do *its* share. Our representatives almost without exception, want to do what is right and it is our duty to let them see our viewpoint. For, due to the development of State and industrial medicine, the nation as a whole has embarked on a programme of State medicine, (hide it from ourselves as we will), and it is up to the medical profession to guide it properly in this programme for they alone have the experience and know what is best.

But up to three years ago the profession

of New Jersey had been largely voiceless. Today, as the result of these labors, there has been created a body of medical men who at least once weekly have been discussing public medical problems and this number and their interest has gradually increased, while the medical profession of New Jersey as a whole has begun to think and act as trained citizens, not simply as individuals. It has begun to realize that it collectively belongs to the public *now*, in peace as during the war; that it is a specialized part of the body politic, and, as such, must occupy a commanding place in those matters for which its education, experience and tradition qualify it alone—the public health.

And above all, we have not sacrificed principles for expediency, for we have held fast to our ideal that the profession must in the future, as in the past, work not for office for itself or its friends, but for the good of the whole people and of the State.

Recommendations.—(1) That the Medical Society of New Jersey endorse the principle and that the work of the Welfare Committee be continued; and that a full-time paid executive be employed under the direction of the chairman of the Welfare Committee.

(2) That the Welfare Committee be instructed to introduce such legislation into the next session of the Legislature to amend the medical practice act as is deemed necessary to furnish greater protection to the profession and the public against unlicensed and unqualified practitioners; that the principles enumerated in Senate Substitute 159 be endorsed.

For some time past counsel has been studying our Medical Practice Act and your committee has received an extensive report showing its inconsistencies and weaknesses. He has been instructed to prepare measures to put "teeth" into the Medical Practice Act. These will be ready at an early date, so they may be fully discussed by the whole profession before the opening of the Legislature.

(3) That the Society endorse the recommendations of Governor Silzer for an educational survey of the State and that it suggests to the Governor that when such is undertaken there be present on the survey committee, a medical man, under whose jurisdiction be the survey of the health and medical matters in public schools.

(4) That sufficient money be appropriated by the Society for the prosecution of this work.

The work of the executive should be to promptly answer every attack on the profession, either collectively or individually, in any

part of the State so that the press would realize that any adverse or unjust criticism of the profession or any of its members would be promptly and ably answered. When the press publish a misrepresentation or an attack on an individual, such as occurred when a suit was brought against two of its members, in which the headlines read, "Railroaded to the Asylum by Physicians," a protest should immediately be made that this statement was not according to fact, and that the physician spoken of had just grievances. The duty of the executive should include a constant publicity in favor of the principles and ethics and practice of the profession. Not a week should pass but with some publicity covering this purpose to give the facts to the press of this State. As I said in my address of three years ago—"to allow a doctor to advertise his cures would be bad ethics, but the time for systematic medical publicity has arrived."

LOCAL ANESTHESIA; ITS MERITS AND LIMITATIONS.*

By Max Danzis, M.D.,
Newark, N. J.

The development and progress of local and regional anesthesia has been rather slow. Its merit in general surgery, particularly in abdominal operations, is still a matter of dispute. This is principally due to the fact that this method requires an accurate knowledge of anatomy and a fairly high degree of technical skill in order to carry out an operation successfully.

Proportionately few surgeons of high degree of skill and experience are willing to give the necessary time required to master the proper method of its administration. It is claimed by some that the merits of local anesthesia are not sufficient to justify its use in major surgery because it is a time wasting procedure, because it does not materially affect the operative results, and because it requires a great deal of patience and a certain aptitude for that particular surgical technic which very few really care to develop. Those who attempt the use of local anesthesia in major surgery only occasionally and in a perfunctory manner abandon it as a tedious and unsatisfactory surgical procedure. They condemn the method as one that is not worthy of general practical application. Even in a modern hospital staff one finds a tendency on the part of some surgeons to look upon a serious attempt to develop that method merely as a surgical hobby.

Admitting that the relative advantages of

regional and local anesthesia over general have been exaggerated somewhat by some who are over-enthusiastic about its use, we cannot ignore the numerous advantages claimed for it by a number of sincere and conscientious surgeons who have made a special study and performed a number of major surgical operations by its use.

At the outset, the writer wishes to state that local anesthesia will not take the place of general anesthesia in the vast majority of major operations. Its exclusive use should not be attempted in abdominal surgery where a thorough exploration of the viscera is or may likely be indicated. Here a nitrous oxid or some other form of anesthesia should always be supplemented. But I do wish to convey in this paper a strong plea that every surgeon should familiarize himself with its use, its indications and the technic that is generally required in the performance of a successful operation.

ADVANTAGES OF LOCAL ANESTHESIA OVER GENERAL ANESTHESIA.

We may divide the advantages of local anesthesia into general and special surgical advantages. The general advantages are those which apply in a certain group of surgical diseases that are complicated by some other pathologic condition in the human organism which contra-indicate the administration of an inhalation anesthesia, such as chronic bronchitis, tuberculosis, acute respiratory diseases, diseases of the blood-vessels, myocardium, renal insufficiency, etc. The special advantages are those that may apply either to a particular patient or to the surgeon.

One of the main advantages of local anesthesia that places it pre-eminently in the front rank of modern surgical advancement is its comparative safety. When properly used, there is hardly any mortality risk. This is particularly true since the strong concentrated solutions that were formerly used were replaced by weaker, less toxic and equally effective agents, such as novocain or procain, apothetin, etc. There were no toxic effects noticed in any one of the cases operated upon by this method in the writer's series. It is the common experience of those who have employed procain very extensively in a great many types of operations that death from local anesthesia has almost completely disappeared from surgical practice.

The postoperative danger following ether narcosis, particularly pulmonary complications which are very often caused or

*Read at the 158th Annual Meeting of the Medical Society of New Jersey, June 6, 1924.

aggravated by its administration are considerably lessened and frequently obviated by the use of local anesthesia. The nausea, vomiting, restlessness, sweating, conjunctivitis and the extreme thirst that very often continue for 24 to 48 hours after ether anesthesia, are totally lacking when local is used. All these complications lessen the patient's postoperative resistance to a considerable extent and often do contribute to a higher operative mortality.

Through the blocking of the operative area, either by local infiltration, field block or paraneural injection, a complete physiologic section of the nerve centers is caused, thus suppressing the reflex action of traumatism upon the nerve center. Shock is thereby greatly diminished. It does away with the extremely unpleasant effects of the first and second stages of ether anesthesia.

It is of special advantage to the type of individual who manifests a certain amount of fear to loss of consciousness which is incidental to general anesthesia. The postoperative pain that is so annoying to highly sensitive persons is considerably lessened, and the postoperative course is much smoother.

It is of advantage to the surgeon in certain types of operations where the patient's co-operation is necessary, such as demonstration of the voice in thyroid operations, finding of the sac in complicated hernias, in cases where the patient's consent is necessary for the performance of a special additional surgical operation, such as orchidectomy in nondescending ectopia testis, etc.

It helps to develop within the surgeon, patience, calm deliberation, a better knowledge of the anatomy of the parts, and a tendency to cautious, clean and careful surgical manipulation.

Novocain, or its equivalent American product, procain, is beyond the experimental stage. It is the most efficient drug in producing local anesthesia that we have today. It has a negligible toxicity in weak solutions, is nonirritating to the tissues and is not decomposed by the addition of adrenalin. It produces a rapid and enduring anesthesia, is soluble in equal parts of water or physiologic salt solution and may be sterilized by boiling. One-half per cent. of that solution is sufficient for minor operations and for major operations of short duration. A 2% solution may be used for nerve blocking, the quantity not to exceed 30 c.c. (Its toxic symptoms are rapid pulse, palpitation, frequent respiration, la-

bored breathing, pallor, cyanosis of fingers, lips and ears, nausea and vomiting, cold sweats, etc.) This drug generally used at present, was used almost exclusively by the writer in a series of 120 operations, including both minor and major surgery. In the first few operations done earlier in this series, beta-eucain in $\frac{1}{4}\%$ normal saline was used. The results obtained with this drug were equally as good as those obtained with the use of procain. It was soon discarded, however, on account of its scarcity in the market, and procain in $\frac{1}{2}\%$ solution was substituted.

Every surgeon is frequently confronted with a surgical operation that is extremely hazardous under general anesthesia. Very often the kind of operation that is to be performed in this particular type of a case is of an emergency nature. The patient's resistance to shock is very low and all safeguards must be thrown around him if his life is to be saved. Under such circumstances, one should be prepared to substitute a less dangerous method, provided that method has been previously given an extensive trial in more favorable cases.

In this series of 120 operations, 105 were of a major character and 15 were of a minor nature. The major operations were mostly abdominal cases and consisted of 49 hernias of various types, 22 appendectomies, 11 thoracotomies, 7 gall-bladders, 3 enterostomies, 2 exploratory operations, etc. (Statistical list appended).

In 50 of these operations, there were no special indications for local anesthesia; in the remaining 70 cases, of which 65 were abdominal operations, positive indications for its use were present. The indications in all major cases consisted of such complications as chronic bronchitis with or without emphysema and bronchial asthma, cardiac decompensation, diabetes, chronic myocarditis, acute respiratory diseases such as pneumonia and empyema. Senility, asthenia, hypertension, nephritis and chronic tuberculosis were the indications in some of the cases. Several of those operated upon by this method were either moribund on admission or were suffering from regurgitant vomiting due to far advanced stages of intestinal obstruction.

Most of these 50 cases of choice operations were operated on early in this series. There was no definite contra-indication to the use of general anesthesia. The procedure was adopted by the writer in order to perfect himself in the use of this method by applying it in more favorable cases where

the time element was not an important factor, so that he would be equipped with a fair degree of skill when the emergency arose.

The choice of anesthesia in these cases was always left to the patient. No one was urged to submit himself to the operation by this method; it was merely suggested to him. The advantages of local anesthesia were explained to him and assurance was given that there would be very little pain. In cases where the indications were distinct, the choice was made by me and the patient told that he must let the surgeon decide for him. Strong emphasis was laid upon the fact that in making the choice of anesthetics the patient and not the surgeon was of primary consideration.

Positive assurance was given to every patient that all our efforts would be directed to produce and maintain a complete anesthesia throughout the operation. The surgeon's confidence in the method is necessary so that he can inspire his patient with the same degree of confidence. Definite promises for an absolutely painless operation should not be made. One should, however, lay particular stress on one's own confidence in the satisfactory results of the operation.

PRE-OPERATIVE PREPARATION.

Easily assimilated, soft or fluid diet should be given during the 24 hours preceding the operation. Purgation or starvation are not called for by the use of this method. The patient is to have a very restful night and may be given some liquid food two hours before the operation, except when operating on the gastro-intestinal tract, particularly the upper abdomen. In that case, the patient should receive no food for at least eight hours because nausea and vomiting may occur during the necessary manipulation due to the occasional handling of the viscera.

Morphin gr. $\frac{1}{4}$ and atropin sulphate gr. $\frac{1}{150}$ was administered by hypodermic in every case to relieve the patient's anxiety and to produce a temporary mental lethargy. The patient's eyes need not be covered; an ordinary screen to obstruct his vision from the operative area is sufficient. Plugging the patient's ears with cotton as recommended by some is in my opinion not necessary; it only arouses a suspicion in the patient's mind and destroys his confidence in the success of the operation at the very outset.

The operative area should be prepared in

the usual manner. Iodin was used in all our cases, except when operating around the scrotal, labial or anal region. Scrubbing with ordinary soap and water, gently mopping the area with a weak solution of alcohol or some other mild antiseptic is sufficient in such cases.

Quite a few of our patients operated on early in this series complained of backache and of a general tired feeling during or immediately after completion of the operation. This was particularly noticed whenever the operation lasted more than three quarters of an hour. It is almost impossible to eliminate the feeling of fatigue which usually follows a prolonged operation. This is principally the result of the patient's mental anxiety and his desire to get through with this ordeal as quickly as possible. But the backache and all other physical discomforts can be obviated. Make sure that the patient feels comfortable on a well-padded operating table. No attempt should be made to restrain him. Care should be taken in preparing the operative area that pain or discomfort should not be inflicted. The operation was disturbed in a few of our cases by the assistant clamping a towel to an unanesthetized skin area, or palpating forcibly an inflamed gall-bladder or appendix.

Rattling of basins, instruments and all other unnecessary hustle and bustle in the operating room should be avoided. All necessary conversation between the surgeon and his associates and all requests for surgical instruments during the various steps of the operation should be made in a subdued voice. It is unwise to call the instrument by name; it should be the duty of the assistant to anticipate every step of the operation and pass the necessary instruments at the proper time. Do not permit your assistants to lean on the patient's legs or chest. Keep the patient's body free from any instruments or dressings. Pain should not be suggested to the patient, nor is it advisable to caution the patient that the operation is about to begin. We usually made it our practice to mention the fact that there will be just a slight pain when the first dermal wheel is made. With a moderate amount of care and proper introduction of the needle, all subsequent injections can be made painlessly. Ten minutes interval was usually allowed from the time of the first injection until the beginning of the operation.

The incision should be made a little longer than that made under general an-

esthesia so as to permit easier exploration. Sharp dissection with scalpel is preferable to scissors. Retractors should be lightly introduced and traction should be exerted in upward direction. Watch the patient's face as an index to pain. Do not repeat to the patient the question, "Does it hurt you?" Avoid traction on tissues, particularly abdominal viscera, if possible.

The operation once begun, an endeavor should be made to work very cautiously and gently within the limits of the anesthetized area, so as to keep the patient in ignorance as to what is actually taking place. We usually tell him at that time that the preliminary injections are still being made and that the operation will soon begin.

The first stage of the operation can always be done painlessly. The patient is made aware that he is being operated upon only when he experiences his first pain. That usually happens either when a nerve filament or a very sensitive structure, such as parietal peritoneum, is encountered. At that time the operation is well under way and some, or most of its important steps have been completed. Then with a few assuring words to the patient that the operation is nearly over, and further anesthetization, his mental anxiety and pain are relieved and the remaining steps of the operation completed.

There is no room for undue haste or careless handling of structures when operating with local anesthesia. The anxiety on the part of the surgeon to complete the operation as quickly as possible very often defeats the object that he tries to accomplish, namely, a perfect anesthesia. The method is frequently condemned by those who employ it occasionally, simply because they have not exercised sufficient care in the delicate handling of the parts, and have lacked the necessary patience and perseverance that are so essential to its successful employment. Careful and sharp dissection, avoiding of crushing or tearing of parts contribute largely toward a successful primary union of the wound. Those who work with local anesthesia must of necessity accustom themselves to very gentle manipulation, restraining themselves constantly from any impulsive action, proceeding with deliberation step by step, watching the structures carefully, and thus contributing to the patient's comfort and a successful operative result.

OPERATIVE OBSERVATION.

Twenty-two cases out of this series were

operated on for either chronic, subacute or acute appendicitis. Most of these were done under local infiltration. Field blocking is not essential in chronic cases and will not obviate the necessity of supplementing nitrous oxid anesthesia in very acute cases. In the chronic and subacute cases, the only discomfort that the patients experienced throughout the operation was a cramp-like pain when traction was made on the meso-appendix. There was nausea when the appendix was ligated and delivered in some cases, and in one case, that of a very nervous patient, who was operated upon for a subacute appendicitis, there was nausea and vomiting.

The pain that accompanies the ligation of the meso-appendix can be obviated by injecting small amounts of the anesthetic solution around the base of the appendix and mesentery, but the pain that is associated with traction of the meso-appendix, while it may be slightly obtunded, can only be completely relieved by splanchnic anesthesia. Regional anesthesia is hardly applicable in the operation because the incision in this case lies in the territory supplied by the branches of the second and third lower dorsal nerves. Each one of these would have to be separated and anesthetized at the point of exit under the borders of the respective ribs before an analgesic field could be secured. In the acute cases of appendicitis, all experienced sharp pain for a few moments when fresh adhesions had to be separated. There was also the usual pain and nausea when the mesentery was ligated. In five of these cases, nitrous oxid oxygen anesthesia was used while the appendix was being delivered and the remaining steps of the operation were completed under local anesthesia.

Cholelithiasis.—The opinion is held by some that gall-bladder surgery is a forbidden field for local anesthesia. There were 7 cases of cholelithiasis in this group and the indications for local anesthesia were absolute in all. Five of these patients suffered from diabetes, 1 from bronchial asthma and 1 from aortitis. The abdomen was opened painlessly in all cases. The parietal peritoneum was anesthetized by depositing about 10 c.c. of the solution between the sheath of rectus and peritoneum. The incisions were always made large enough so that if exploration was necessary, the hand could be introduced into the abdomen with ease. The peritoneal surfaces on either side were always anesthetized; the summit of the gall-bladder was

also infiltrated and grasped with sponge forceps. Very little discomfort was experienced by the patient when the gall-bladder was incised and contents evacuated. One case of cholelithiasis with a chronic empyema of the gall-bladder continued to smoke cigarettes, feeling fairly comfortable throughout the operation.

In the two cases of thyroidectomy included in this series, the operation was supplemented by nitrous oxid anesthesia during the time when the gland was being delivered and the poles ligated. The procedure was of my own choice. I felt that the operation could be hastened by this method without being harmful in any way to the patient.

In no type of operation is local anesthesia more indicated than in enterostomy for intestinal obstruction. Cases of death from drowning by intestinal contents during the first stage of general anesthesia are reported. Septic bronchitis due to inhalation of septic material and intestinal secretion is not of an uncommon occurrence. There were three enterostomies in this series done painlessly throughout after a careful infiltration of the parietal peritoneum before the hand was introduced into the abdomen to grasp a loop of intestine. In one case where exploration was necessary, nitrous oxid anesthesia was supplemented.

Hernias.—The operation for the radical cure of inguinal hernia and the inguinal route for the cure of femoral hernia is of all other surgical operations best adapted for the use of local anesthesia. Even as early as 1887, a number of surgeons attempted to perform herniotomies by the use of this method. On account of the strong concentrated solutions of cocaine used at that time, some fatalities were reported and the method was not generally adopted. Doctors John Wyeth and Boudoin used it almost exclusively in their hernia operations, with the percentage of cures equal to that of general anesthesia.

In this type of operations we really combine regional with local anesthesia. In addition to the local infiltration, the ilio-inguinal ilio-hypogastric and the genital branch of the genitocrural nerve may be anesthetized by paraneural infiltration. When this technic is properly carried out, particularly in simple inguinal hernias, the operation can be done painlessly. In fact, some of my patients were not aware at any time of the stage of operation. They continued to ask while the operation was going on, "When will you begin" In some

of these cases, varices of the cord were resected. The neck of the sac should be infiltrated before ligation and the conjoint tendon should be infiltrated whenever the sheath and rectus muscle are to be included in the ligature.

In operating upon a strangulated hernia, one should bear in mind that there is always an inflammatory reaction present around the constricted area which is quite painful to manipulation. Therefore, before any attempt is made to relieve the constriction, a careful infiltration should be made around the sac proximal to the point of constriction. Before the sac is opened, the patient should be put in a moderated Trendelenburg position in order to be able to reduce its contents. If the sac is very large, it is advisable after it is opened and its contents reduced, to deposit about 10 c.c. of the solution on its inner surface. A complete anesthesia is thereby produced and the remaining steps of the operation can be carried out without any discomfort to the patient.

Femoral.—All these femoral hernias were done by the inguinal route. This operation offers one of the best proofs of the efficiency of local anesthesia. A wide exposure and extensive dissection of structures are indicated. Considerable traction upon the sac is necessary in order to convert the femoral into an inguinal hernia. Consequently the parietal peritoneum which we all know is very sensitive, undergoes considerable manipulation. This can be obviated by infiltrating the area around the femoral canal and the proximal portion of the sac so that it can be drawn through the femoral ring painlessly. There were four femoral hernias in this series; one was strangulated for 24 hours. The anesthesia proved very successful in all these cases.

Ventral.—In this type of operation an attempt should be made to separate and carefully dissect out all the structures of the abdominal wall, particularly the fascia, before the peritoneum is opened. Shock and pain are thus considerably lessened and in many instances completely obviated. After the sac has been completely isolated and the overlying fascia separated and its edges freshened, a circular infiltration is then made close to the free edges of the fascial planes before opening it. There is no need of incising the sac throughout its entire length. A small incision should first be made and a careful inspection of its contents noted. Adhesions should be separated by sharp dissection, the patient put in Tren-

delenburg position and if extensive adhesions are present further infiltration of the parietal surface of peritoneum made if necessary. This permits painless separation of omental or intestinal adhesions to parietal peritoneum. The entire redundancy of the sac can then be resected without pain and the remaining steps of the operation completed. Every effort should be made to consume a minimum of time in keeping the peritoneum open because in my own experience it was noted that as soon as the sac was opened, the pulse rate would become markedly accelerated, the skin became colder and face slightly cyanosed. The condition the patient was under during these manipulations would remain the same and he would return to normal only when the peritoneum was closed.

Umbilical.—The small or moderate sized umbilical hernia can and should always be repaired under local anesthesia. A field block method was adopted in all our cases. It produces a better and more prolonged anesthesia and permits a much clearer dissection of the sac and its contents. Even with a moderate degree of care and skill the operation can be carried out painlessly. The only stage of the operation which may be associated with some discomfort is when the sac, that is usually adherent to the umbilicum, is excised with it. We made a point to carefully watch for any manifestations of pain during this stage. As far as I can remember, none of our patients complained of pain at that time. In some of these cases, there were adhesions present between the intestines and the upper angle of the hernial ring. One was a case of a man 70 years of age who suffered from a chronic partial intestinal obstruction due to a firm adhesion between a loop of intestine within the hernial sac. Sharp dissection was necessary to separate these adhesions, which left a raw intestinal surface that required careful peritonealization. This patient was very talkative throughout the operation and assured us that he was perfectly comfortable. We have had a similar experience in the case of a strangulated hernia in a woman of 65 who suffered from an advanced form of cardiac disease. She developed an acute intestinal obstruction due to her strangulation. Extensive resection of adherent and strangulated omentum was also necessary. There were no postoperative complications; her cardiac symptoms were not aggravated and she has had no recurrence of her trouble since.

Recto-Vesical Fistula and Imperforated

Anus.—Local anesthesia is applicable in pediatric surgery as is demonstrated in two cases of pyloric stenosis done under local, one of which was supplemented by inhalation anesthesia just long enough to deliver the pyloric tumor through the wound. The third infant operated on in this series was three days old, and suffered from an imperforated anus. The anal canal was completely obliterated and on the third day the nurse noticed some fecal discharge through the urethra. The general condition of the infant was fair, but local anesthesia was selected because it was thought that the child had a better chance of surviving the operation. The perirectal space was infiltrated and an incision was made in the region of the anus, the perirectal fat carefully separated, blind pouch of the rectum was dissected out and mobilized. It was sutured with three day chromic gut, the rectum was opened and a circular suture employed to bring the rectal edges to anal opening. The infant gave no evidence of pain throughout the operation; it cried occasionally; the thigh and hip muscles were completely relaxed and the infant became quiet when it was given a bottle.

Thoracotomies.—Of the 11 thoracotomies performed by me, 1 was for a lung abscess following pneumonia and 10 were for empyema. Eight of these empyema operations were in children and 2 in an adult. A wide infiltration of the operative area suffices to abolish all sensation until the intercostal muscles and periosteum are reached. The intercostal nerve can be blocked by infiltrating the intercostal muscles and the lower border of the rib. Before separating the periosteum, the subperiosteal spaces above and below should be infiltrated through a very fine needle. The rib can then be resected without pain. Our patients only became aware of this step of the operation by the click of the shears in severing the rib. The operation for lung abscess was performed on a man aged 50 who suffered for several weeks from the usual symptoms of that disease. X-ray and bronchoscopy revealed an abscess in the right middle lobe. Injection of guminal into the abscessed cavity through the bronchoscope and all other medical measures failed to give him any relief and operation was then decided upon. Paravertebral infiltration of 4th, 5th, 6th and 7th thoracic spaces were made. The skin and muscles over the area of incision were also infiltrated. Incision was made on right chest from 4th to 9th ribs. Periosteum

from 5th, 6th and 7th ribs was separated and portions of ribs resected. Firm adhesions between parietal and visceral pleura were present. The one-stage operation was considered safe in this case. The abscess was located with a needle through which thick pus was withdrawn. A grooved director was then inserted along the course of the needle and the opening enlarged by blunt separation. Before the incision was made, the patient showed some evidence of fear and lack of confidence as to the outcome of this procedure, but with our assurance that he would not suffer any pain, he was convinced of the efficacy of this method and co-operated with us throughout the operation and showed no ill effects. The patient was discharged after several weeks as cured without occurrence of any other complication.

CASES SUPPLEMENTED BY NITROUS OXID.

Of the 105 major operations in this series, only 12 required some form of general anesthesia during the crucial stage of the operation. None of our hernia cases required any other form of general anesthesia. In the large incisional hernias, patients were told to breathe deeply and to avoid straining when the peritoneum was opened. During the separation of adhesions and ligation of omentum, the patient was kept in the Trendelenburg position and restored to normal when the peritoneum was closed. Five cases of acute appendicitis required the administration of nitrous oxid anesthesia for several minutes while adhesions were being separated and the acutely inflamed appendix delivered. At no time was it necessary to keep the patient under deep general narcosis until the completion of the operation. Three gall-bladder cases suffering from an acute cholecystitis demanding surgical intervention required supplemental gas oxygen anesthesia. The general condition of these patients was such that a prolonged general anesthetic was considered extremely hazardous. Within the last six months some of our cases have been supplemented with ethylene instead of nitrous oxid. We found that it produced some relaxation of the abdominal wall, is a much smoother anesthesia and is almost entirely free from any unpleasant after effects. Nausea and vomiting were rarely present following its administration. Two of the exploratory laparatomies for upper abdominal malignant disease also required administration of nitrous oxid or ethylene during the exploratory stage. One interposition operation, one enterostomy

and one gastro-enterostomy also required some supplemental anesthesia.

Postoperative Complications. — A large proportion of the patients reported in this series suffered from chronic respiratory diseases which constituted a definite indication for local anesthesia. It was not uncommon in our experience to find that in some these symptoms were markedly aggravated during the first two or three postoperative days. Posture during and after the operation has not materially changed this condition. In some cases, the respiratory symptoms assumed very serious aspects during the first 48 hours following operation. One cannot say with any degree of certainty whether or no these patients would not have suffered much more serious respiratory reverses under the influence of general anesthetic. We have no record of a case of pneumonia developing in those cases that were free from any previous respiratory disease. In this group are included 10 appendectomies, 23 herniorrhaphies, 1 jejunal fistula. Of the more serious complications that occurred in this series during the postoperative course, the following are of interest:

1. A. G., with bronchial asthma of many years' duration was operated on for a left inguinal hernia without any immediate postoperative effects. On the tenth day following the operation he suddenly complained of severe pain in his chest, dyspnea and marked cyanosis. His pulse became very rapid temperature rose to 103° and the patient appeared very ill. Within a very short time after this onset, he expectorated blood freely and on the following day evidence of consolidation appeared on the left lower lobe. He ran a course typical of a pneumonia which lasted about 10 days and subsequently developed a phlebitis of his left leg. He made a slow and painful recovery.

2. H. H., acute appendicitis, chronic bronchitis and emphysema. Patient was very septic, anesthesia supplemented by nitrous oxid. Persistent vomiting and distension with eventration of the wound on the fifth day, followed by jejunal fistula and death.

3. L. F., no previous history of diabetes; suffered from chronic bronchitis. Had previous operation for an inguinal hernia. Urine on admission showed 0.3% sugar, blood sugar 107 mg. Patient suffered from a large and troublesome hernia on the opposite side that could not be retained by a truss. Operation under local

anesthesia was thought to be fairly safe in his case in view of the fact that his blood sugar was normal and the general condition good. The usual operative procedure was carried out and the patient was rather in a bouyant spirit throughout the operation. Twenty-four hours following operation, his cough became markedly aggravated, his face became cyanotic, temperature went up to 103° and he had a sudden attack of marked tachycardia, his pulse becoming almost imperceptible about 36 hours after operation. These symptoms subsided within 12 hours but within 48 hours after operation we noticed some edema, discoloration and coldness of scrotum. The wound looked perfectly clean without any signs of induration or gangrene. His temperature then began to rise again. The scrotum rapidly enlarged and became completely gangrenous. Simultaneously, gangrenous areas appeared on the perineum and the inner surface of the right thigh also began to show evidences of skin destruction. His blood sugar at that time went up to 250 mg. and the urine showed 2.5% sugar. Patient became very toxic and irrational. Gangrene extended posteriorly to the buttocks, sacral region and the inner aspects of both thighs. The wound area was not involved so that we cannot attribute this condition to the effect of the adrenalin in the solution. Patient died on the 7th day with all the symptoms of acidosis and sepsis.

4. R. P., acute dilatation of stomach following operation for strangulated hernia on an old woman. Only local anesthesia was used in this case. Jejunostomy was done after repeated gastric lavage failed to bring any relief. Patient's condition grew progressively worse. Died on the fourth day.

The healing of the wound in all clean cases with the exception of a few, was by primary union. Two of our cases developed hematoma. In several of our abdominal operations, we noticed a certain degree of tumefaction along the wound edges which persisted for a much longer period of time than one would normally expect. Occasionally we found a slight destruction of the epidermis along the course of the superficial dermal wheal. In only one case, however, was there any sloughing (in addition to the diabetic gangrene reported above). This was in a patient who was a confirmed alcoholic and suffered from a chronic bronchitis of many years' duration and his general condition was very poor. This man finally recovered.

Limitations of Local Anesthesia.—Local

anesthesia has its limitations even in the hands of those who are using it extensively and are thoroughly familiar with all its phases. Probably one of the reasons for its slow recognition may be due to the fact that its merits were somewhat exaggerated by those who were over-enthusiastic about its use.

It is contra-indicated in acutely localized inflammatory conditions such as abscess, cellulitis or malignant growths.

Upper abdominal operations, particularly where a thorough exploration of the viscera is necessary cannot be fully completed without the aid of a general anesthesia. To persist in continuing operative manipulation when the pain becomes acute and abdominal rigidity marked is only courting failure. It may cause considerable traumatism to the neighboring parts with all its sequellae and will only help to discredit the method in the eyes of the patient and the surgeon.

Pulmonary complications are not totally obviated by local anesthesia. They are less common in those cases where the existence of the respiratory disease, such as chronic exudative bronchitis, is of long standing. But that the condition is aggravated in a fairly large proportion of cases is borne out by clinical experience, including my own series. A large percentage of pulmonary complications are of embolic origin and may occur in regional as well as after general anesthesia.

In a study of postoperative pneumonias made at Mount Sinai Hospital and reported by Dr. H. Elwyn,¹ it was found that out of a series of 88 operations performed on the gall-bladder, appendix and hernia under local anesthesia, the incidence of post-operative pneumonia was as high as 12.5%. It is not stated, however, whether these cases include such patients as have suffered from previous pulmonary disease. Our own experience does not bear out these findings.

The use of local anesthesia may also be limited by the mental state of each individual patient. No amount of assurance will convince some patients of its efficacy and they will not submit to it even when the operation is of a minor nature. It was the frequent experience of the writer, when offering this method to patients for a minor surgical operation, to be told that they would rather undergo the after effects of a general anesthesia than face a surgical ordeal in a waking state.

CONCLUSIONS.

1. Local anesthesia has its distinct advantages in properly selected cases and it is assuming a very important position in general surgery.
2. Every surgeon should familiarize himself with its use, indications and technic.
3. Choice of anesthesia should be left to the patient after its advantages are explained to him, unless there are distinct contra-indications to the use of general anesthesia. Under such circumstances, the surgeon should make every effort to convince the patient of its efficacy and choose for him.

It is no easy task that the surgeon sets for himself when undertaking an operation with local anesthesia. It is not a time or energy saving method. An operation that can be done in 25 or 30 minutes consumes probably twice that length of time when done under local anesthesia. The surgeon must be temperamentally fitted, gentle and have firm control of his patient. It requires self-confidence, patience and self-restraint. The ordeal is at times just as exhausting to the surgeon as it is to the patient. It is a great source of gratification, however, to the surgeon after the operation is completed to find a perfectly contented patient, grateful for what has been done for him, free from all the unpleasant after effects of a general anesthesia. One feels that his efforts are well repaid.

1. Anesthesia and Analgesia, April, 1924.

TABULATION OF CASES.

Appendectomies	22
Adenoma of breast	2
Biopsy Carcinoma of tongue.....	1
Cholelithiasis	7
Enterostomies	3
Exploratory Laparotomies	2
Fistulas	2
Perineal	
Jejunal	
Fibroid of Vulva	1
Foreign body in buttock	1
Gastro-enterostomy	1
Goiter	2
Hernia	49
Hemorrhoids	2
Interposition operation	1
Imperforated Anus	1
Lipoma	3
Fibroma of Leg	1
Osteomyelitis	1
Omentopexy	1
Pyloric stenosis (congenital)	2
Pilonidal cyst	2

Sebaceous cysts	2
Suprapubic cystostomy	2
Thoracotomy	11
Empyema	10
Lung Abscess	1
Total number of operations	120
Major	103
Minor	17

Operation	Choice	Indication	Total
Foreign Body	1		1
Gastro-enterostomy	Chronic T. B.		1 1
Interposition operation	Hypertension		1 1
Hemorrhoids	2		2
Lipomas	3		3
Osteomyelitis	Very septic		1 1
Omentopexy	Bronchitis & emphysema		1 1
Pilonidal Cyst	2		2
Suprapubic cystostomy	Diabetes		1 2
	Myocarditis		1

Operation	Choice	Indication	Total
Appendectomy	10	Chronic bronchitis	5 22
		Hypertension	1
		Asthenia	2
		Diabetes	2
		Chronic T. B.	2
Hernia	23	Chronic bronchitis	13 49
		Senility	2
		Myocarditis and senility	4
		T. B.	2
		Diabetes	3
		Moribund (admission)	1
		Hypertension	1
		Diabetes	5 7
Cholelithiasis		Bronchial Asthma	1
		Aortitis	1
		Lung Abscess	1 11
Thoracotomies		Empyema	10
Enterostomies		Fecal vomiting & moribund	3 3
Goitre	2		2
Pyloric Stenosis	2		2
Exploratal Laparotomy		Myocarditis, bronchitis & senility	2 2
Imperforated Anus		Malnutrition	1 1
Adenoma of breast	2		2
Biopsy of tongue	1		1
Fistulae			2
Perineal	1	Chronic	
Jejunal	1	bronchitis	1
		Progressive cholemia & asthma	1
Fibromas	2		2

All He Was Doing.

Little Bobby came crying into the house, rubbing the places where he had been butted by a pet sheep.

"But what did you do", his mother demanded, "when the sheep knocked you down?"

"I didn't do nothin'," Bobby declared protestingly. "I was getting up all the time."—Ladies' Home Journal.

THE TREATMENT OF DIABETES.*

By Martin J. Synnott, M.D., F.A.C.P.,

Colonel, Med. O. R. C., U. S. Army.

Montclair, N. J.

The literature on the treatment of diabetes is now so voluminous that I shall limit myself to a brief outline of the practical application of recent successful research in Canada and the United States. The procedure which I shall describe is for the most part that used at the Presbyterian Hospital in New York City.

Diabetes mellitus is a disorder of metabolism characterized by an excess of sugar in the blood and by the presence of sugar in the urine,—on a diet not containing excessive amounts of carbohydrates. Its characteristic symptoms are polyuria, excessive thirst and hunger, loss of weight, dryness of mouth and skin, sometimes boils, carbuncles, and nervous affections. There is often loss of sexual power. Spontaneous gangrene is an occasional occurrence.

The most common cause of diabetes mellitus is destruction of the islands of Langerhans of the pancreas, which Islands produce the internal secretion necessary for the metabolism and utilization by the body of carbohydrate food intake. This internal secretion is taken up directly by the blood of the pancreas, whereas the secretion of the remaining glandular—or acinous,—structure of the pancreas is poured into the duodenum through the duct of Wirsung where it plays an important function in intestinal digestion.

Damage to the islands of Langerhans may take place in one of several ways: (1) During an acute infectious disease, such as scarlet fever or diphtheria, toxins are produced which may be carried by the blood to the pancreas and destroy in greater or less degree the secreting function of this organ. Allen has aptly referred to this group as "the vestigium of old burnt-out conflagrations." (2) There are other less acute involvements of the pancreas due to the blood-borne infections from some toxic focus elsewhere in the body. The etiology of such cases reminds one strongly of pyelitis

which, Rosenow has demonstrated, may be the result of an infected tooth, or tonsil. (3) A certain percentage of cases of diabetes is the result of an ascending duct infection involving first the bile-ducts and gall-bladder, and thence,—by direct extension or through the adjacent lymph supply,—the pancreas. The usual sequence of such a condition is first a bacterial infection starting in teeth, gums, tonsils or accessory sinuses; and then as a result of direct swallowing of toxic material, an infectious achylia gastrica or hyperchlorhydria, or peptic ulcer, and an infectious duodenitis, with subsequent involvement of bile-ducts, gall-bladder, adjacent lymphatics and pancreas.

In the first of these three classes are usually found the juvenile diabetics. In the second class are the young adult diabetics, so many of whom are found to have infected tonsils. In the third class are the patients who develop diabetes late in life. These patients almost all have pronounced oral infections, involving teeth, tonsils, and sinuses. They frequently give symptoms of, or relate a definite history of infections of the biliary or upper abdominal region.

The severity of a given case of diabetes naturally depends on the amount of damage done to the pancreas. If there has been an extensive destruction of the Islands tissue, the diabetic condition will be more grave. If on the other hand the damage has been only slight, the resulting diabetes will not be severe, and only very slight dietary regulations will be necessary.

Before starting any specific mode of treatment, a complete and painstaking physical survey should be made of every patient,—evidences of pulmonary tuberculosis or of hyperthyroidism being carefully looked for. Basal metabolism tests, complete urine analysis and blood chemistry tests should be done in every case.

At the outset, focal infection in teeth, tonsils or accessory sinuses should be removed if this is possible. While the destroyed Islands tissue of the pancreas cannot be restored, the progressive nature of the disease may be arrested by prompt and thorough surgical excision of infected tissue. The technic of duodeno-biliary nonsurgical drainage originated by Dr. B. B. Vincent Lyon of Philadelphia, enables us to determine easily and surely whether or not there is

*Read at the 158th Annual Meeting of the Medical Society of New Jersey, Atlantic, City, June 6th, 1924.

an ascending infection involving the bile-ducts, and when such an infection is found to exist, the Lyon treatment is definitely indicated.

The general aim of treatment in diabetes is the relief of symptoms and the restoration of normal body weight, vigor and activity. This can be accomplished only by the use of a diet, properly utilized, which is adequate for the patient's needs. The normal dietary requirements of most individuals lies between 30 and 40 calories per kilogram of body weight,—depending on size, age, sex, kind of work and habits of life. The caloric requirements have been accurately determined by basal metabolism studies, and tables prepared by DuBois and others which enable us to promptly determine the needs of an individual case after obtaining the patient's weight in kilograms and height in centimetres. Certain corrections must then be made, because the younger individual will require more calories than the older, and the laborer more than the man of sedentary habits. The case of diabetes complicated by a wasting disease like pulmonary phthisis will require a diet higher in calories than the uncomplicated one.

In diabetes our aim is to prescribe a diet on which the patient will be happy, which will enable him to maintain his working power and on which his urine will be free of sugar and acetone, and the blood sugar brought down somewhere near the normal level.

With the aid of insulin,—the epoch-making discovery of Dr Banting,—this is now quite easy of accomplishment. Formerly, before insulin was available, the treatment most successfully employed in severe cases of diabetes, was the so-called "starvation" regime of Allen;—under this plan, when properly and intelligently applied, many lives were undoubtedly saved and the pancreatic disease often arrested with subsequent increased carbohydrate tolerance. The objection to this plan of treatment was the extreme asthenia and complete loss of working power of the patient, along with the difficulty experienced in enforcing a diet so distasteful and rigorous to the patient and his family that its success depended on the discipline of a highly efficient sanatorium regime which all could not afford.

Fortunately, as pointed out by Joslin,

diabetes in the vast majority of adult cases is a very mild disease. Many individuals have it for years without symptoms and learn of its existence only in the course of an insurance or life-extension examination.

It is well known that obesity is often associated with early diabetes. Allen has described a condition which he calls "potential diabetes." Patients in this class are obese middle-aged individuals, very often women, who lead sedentary lives, over-eat, and who come to the physician for the relief of an unexplained neuritis. On examination they are found to have a low blood pressure,—100 or less systolic,—and a high blood sugar, with sugar-free urine. This condition may be diagnosed only by a chemical analysis of the blood.

Individuals in this class, as well as true diabetics, must be convinced at the very start of treatment that they cannot over-eat and that their caloric intake must be such as will reduce the body weight to a normal standard. Insurance figures clearly demonstrate that the expectation of life is notably longer for persons somewhat under-weight, and it is a fact that with the under nutrition and inadequate food supply of the population of Central Europe during the World War, the incidence of diabetes became very low. It has also been clearly established that the dangers from acidosis are less in the lean individual.

The normal diet for a person of average size, say 70 kilograms, or 154 pounds,—will be given in the neighborhood of 400 grams of carbohydrate (1,600 calories), 100 grams of protein (400 calories) and 100 grams of fat (900 calories), or 2,900 calories, which is approximately 40 calories per kilo of body weight.

At the start of treatment of a given case of diabetes, the "carbohydrate tolerance" is determined by putting the patient on a test diet (Joslin or Woodyat) the calories and carbohydrate percentage of which are reduced daily until the urine is sugar-free. When the urine is sugar-free, increases are made daily or every two or three days in the calories and the carbohydrate allowance until the sugar reappears in the urine. The number of grams of carbohydrate which the patient is able to metabolize before sugar re-

appears in the urine denotes the "carbohydrate tolerance."

Most diabetics do not find a diet which contains less than 100 grams of carbohydrate very palatable, so that a tolerance of less than 100 grams usually indicates the use of insulin. If the patient, on a carefully computed diet, is found to have a carbohydrate tolerance above 100 grams daily or is able to metabolize 600 or 700 calories in excess of his basal metabolism requirements, no insulin is needed. Mild cases of diabetes like this, may be controlled satisfactorily by diet.

The method at present used in the Presbyterian Hospital in New York City is to give the patient at the start of treatment, 1 gm. of protein per kilogram of body weight, and an equal amount of carbohydrate making up by addition of fat a caloric intake of 25 to 30 calories per kilogram of body weight. Should the urine become sugar free on this diet, the full amount of carbohydrate which can be taken without insulin is ascertained by gradually increasing the amount of this food stuff 10 gms. per diem until sugar reappears in the urine. If the amount of sugar reaches 150 to 200 gms, before glycosuria develops, the administration of insulin is not considered to be indicated. A diet containing carbohydrates in excess of 100 grams daily may be made perfectly palatable, satisfying and sustaining to the average patient.

Growing children, emaciated patients, consumptives, will require more than 1 gram of proteid per kilo,—often as much as 2.5 gms. per kilo or 1 gm. per pound.

To obtain the same caloric intake in the diabetic as given in a normal diet of 2,900 calories, made up of 400 gms. carbohydrate, 100 protein and 100 fat, it will be seen that the adult diabetic patient of the same weight, receiving a ration of 70 grams carbohydrate, and 70 grams protein will require about 240 grams of fat. It must not be forgotten in figuring out our diabetic diets that 58 per cent. of the proteins in the food intake and 10 per cent. of the fat is metabolized into lactic acid. In the normal individual this is excreted as carbondioxid and water, but in the diabetic it is converted into dextrose. Various metabolism investigators have shown that if the proportion of carbohydrate and protein intake to the fat intake exceeds a certain ratio, symptoms of acidosis are apt to develop in the dia-

betic patient. "Fats burn only in the flame of carbohydrates," and if the supply of carbohydrate food is insufficient to produce a proper flame the fats do not burn properly but merely smoulder, producing ketone substances,—acetone, diabetetic acid and B-hydro-oxybutyric acid. According to the Ladd-Palmer formula which is generally adopted by diabetic specialists, the proportion of the carbohydrate plus 60 per cent. of the protein to the fat in the diabetic diet must not exceed the ration of 1 to 3, which would be expressed thus:

$$\frac{100\% \text{ C} + 60\% \text{ P}}{100\% \text{ F}} = 1/3$$

It will be seen that the diet outlined above is practical according to this standard. On the basis of the Ladd-Palmer formula it would be as follows:

$$\frac{70 + 42}{240}$$

$$240$$

or 1 to 2.1,—which is well within the limit of safety.

There are various methods of finding out what dosage, if any, of insulin is needed to give the diabetic his maintenance diet requirement. For the case of average severity, not exhibiting a marked degree of acidosis, a diet similar to the above may be used at once,—i. e., 70 C 70 P 240 F,—and careful daily observation made of urinary sugar excretion, maintaining the carbohydrate intake about the same for each of the three meals. If sugar appears one may give a total insulin dosage equally spaced, twenty minutes before the three meals, corresponding to 1 unit of insulin for each 2.5 gms. of glucose excreted in the urine. Thus if the sugar excreted in the urine during 24 hours amounts to 25 gms., the daily dose of insulin for such a patient would be 25 divided by 2.5 or 10 units of insulin. This would be given by hypodermic injection in two or three divided doses, always 20 minutes before meals. If such an amount of insulin fails to clear the urine of sugar, divided urinary specimens, that is to say, separate collections and analysis of the amounts voided between each of the meals,—that between breakfast and lunch, that between lunch and dinner, that between dinner time and the following breakfast,—may show an excess of sugar excretion during one or more of these periods, and the further dosage of in-

sulin may then be adjusted with a view to increasing it at the time when sugar appears and reducing it in the sugar free intervals. Should sugar appear in all, a cautious increase in the insulin dosage may be made, 1 to 4 units at each dose, until the glycosuria disappears. It will be seen that this method does not reduce the diet below normal maintenance at all during the period in which the proper dosage is being ascertained. In many cases it has been the practice at the Presbyterian Hospital to reduce the food intake, at the same time increasing the insulin until glycosuria disappears and from that point, by step like progression, first the one and then the other, to increase both food intake and insulin up to a point where the maintenance requirement is reached, keeping the urine during this period, as far as possible, free from sugar. This method has to commend it that where much acidosis is present, it is more readily cleared up.

The results of insulin treatment are certainly most remarkable and gratifying. The patient begins to gain in weight almost at once. The distressing symptoms of diabetes are immediately relieved; the hunger, thirst and weakness disappear, the sunken cheeks fill out and the characteristic facial expression of depression is replaced by a happy, optimistic smile. There is a prompt gain in the patient's strength and working power.

We have reason to believe that a diabetic patient's tolerance for carbohydrates is increased as a result of insulin treatment, and that the pancreas regains a portion at least of its lost function.

The most important point to be borne in mind in administering insulin, particularly during the early observation period, is the avoidance of too large doses of the extract, the effect of which varies in different individuals,—in order to avoid the danger of a hypoglycemic reaction.

Hypoglycemic shock is caused by a sudden and marked lowering of the blood sugar to a critical level,—about 75 milligrams of sugar to 100 c.c. of blood. With increased knowledge of the use of insulin, these alarming reactions will become less and less frequent. The severity and time of appearance of the symptoms bear some relation to the excess of the overdose. In patients receiving insulin three times a day before meals, they usually occur in the late afternoon or in the evening, their appearance being

somewhat retarded by the intervening food. Where no carbohydrate is injected to counteract the effect of the drug, symptoms may occur as early as thirty minutes after the injection. The first thing usually complained of is a sense of lack of well-being, or of queer feeling, as an "inward trembling," which the patient cannot well describe but which he asserts he has never experienced before. A feeling of sudden and pronounced hunger, less frequently of thirst, is often the first thing noted. Pain is not usually complained of. At times there are psychic phenomena, especially in children, which take the form of cries, delusions and resistance. A marked lowering of body temperature occurs, as low as 96.5° (rectal), and an increase in pulse rate is found, especially in children. Except in the latter stages of profound shock, there is no constant reaction of blood pressure. Dilatation of the pupil and facial pallor or flushing have been noted. Ringing in the ears may be complained of. The most striking objective phenomenon is profound sweating, at first on the face, then drenching the entire body. Later, trembling and twitching of the extremities, with extreme nervousness and weakness occur, and unless medication is given, the condition may progress to convulsions, unconsciousness, delirium and even death.

The specific treatment of this condition is the administration of carbohydrate, usually in the form of orange juice or sugar. Candy and glucose, sweet crackers or any other form of carbohydrate is useful. Often a hot drink, if the attack is not severe, will overcome it. Adrenalin in 1 to 1,000 solution, 5-15 minims, is a quick temporary expedient, but should always be supplemented by other treatment. It has recently been discovered that pituitary extract also has like properties, and on the other hand it has been found that a preceding injection of ergotoxin will greatly increase the insulin effect. In case of a severe reaction when the patient cannot swallow and emergency treatment is necessary, it is wise to give first a hypodermic injection of adrenalin and to follow it with glucose, injected either subcutaneously or intravenously or by enema or gastric gavage. The injection of adrenalin is always advised if the reaction is at all severe, and if given promptly will, as a rule, be sufficient by itself to relieve the condition, because adrenalin

very quickly mobilizes the glycogen in the liver.

Prompt treatment, as indicated above, gives almost immediate relief, even in severe reactions. Hypoglycemia is more readily produced in the blood of a diabetic than in a normal individual, because the livers of diabetics do not store glycogen, and insulin abstracts glucose from the blood of the diabetic, faster than the liver can supply glycogen.

In order to avoid hypoglycemic shock, the most important precaution after proper and conservative estimation of the daily dose of insulin, is the time selected for the injections. The effect of insulin on the blood sugar curve, producing a lowering, follows the subcutaneous injection usually within 30 minutes. The injections should therefore be given, as already stated, 15 to 20 minutes before meal time, so that the insulin will act on the carbohydrate of the food and not be present at any time in excessive amounts, thus possibly producing alarming symptoms.

REMOVAL OF STENSON'S DUCT FROM THE RIGHT ANTRUM BY PLASTIC METHODS, AND ITS MECHANICAL COUNTER- PART.*

By J. Eastman Sheehan, M.D., F.A.C.S.,
New York City.

Associate Surgeon and Lecturer to the International Clinic for Oto-Rhino-Laryngology and M. R. S. M., London; Assist. Professor of Laryngology, New York Post-Graduate Medical School and Hospital; Consultant Surgeon Specialist to All Souls' Hospital, Morristown, N. J.; St. Francis Hospital, Poughkeepsie, N. Y., and Port Jervis Hospital.

A female, aged 60, was operated the early part of December, 1922, for empyema of the right antrum by the Caldwell-Lue method. Severe headaches and earaches followed the operation, with more or less continuous flow of a watery substance from the nostrils, particularly the right one, and aggravated at and during meals. Eighteen days after the antrum operation, she again entered the hospital and was operated upon for rightsided mastoiditis. A fortnight after the mastoidectomy,

the same operation was performed on her left ear, the condition being complicated by double lobar pneumonia. After going through a stormy and agonizing period of some six weeks, she was discharged from hospital, none the worse for her very trying experiences, except that the watery discharge from the nostrils still continued.

It was for this very annoying condition she wandered from pillar to post to seek relief. During the past summer she was referred to Dr. Charles Imperatori who, after giving her case much study, concluded that the duct of the parotid gland had become embedded in the healing scar of the antrum. Dr. Imperatori attempted to repair the defect by utilizing a flap of cheek mucous membrane. This relieved her condition for some time as salivation now took place through the mouth and not through the antrum. Subsequently, during the healing process, the flap was caught up into the extensive healing scar and she reverted to her old state of salivating through the antrum.

Upon my return from Europe in November, Dr. Imperatori asked me to see the case to determine whether by plastic methods the condition could be relieved. I took the case in hand, as it presented such sporting qualities.

OPERATION

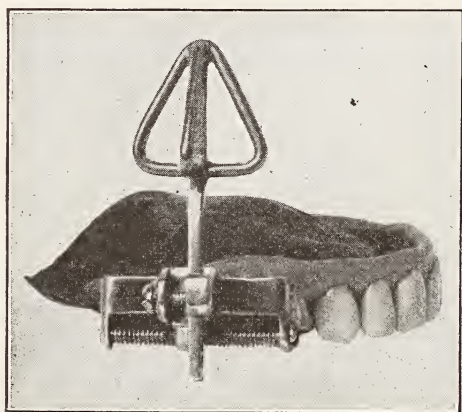
I first referred her to my brother, Dr. Beaman Sheehan, who made and attached a cup shaped splint to her dental plate, as her mouth was edentulous. To the center of the splint was attached an upright semi-flexible bar of metal, topped with three triangular wings to carry the Stent.

I purposed to epithelize the scar tissue which covered the antral wall on the one part, and the cheek area on the other, figuring that after successful epithelization of the opposing surfaces, it would be quite impossible for these surfaces to adhere, and that the flow of saliva would take place via the natural route. This theoretic conclusion was subsequently justified by operation.

On January 2, 1924, using a local anesthetic, Dr. Charles Imperatori observing, I incised the right gum area along the course of the old incision and separated the cheek tissue from the scar-covered antrum wall, incidentally freeing Stenson's duct from the contractures. A

*Read before the N. Y. Academy of Medicine, March 26, 1924.

mould of Stent was sterilized by boiling. A model of the raw area was made by inserting the sterile Stent, made soft and pliable by immersion in hot water, in the newly made cheek cavity, through the gingival incision. The Stent was pressed upward, then laterally, and then forward, until all the exposed raw area was com-



pletely covered and an excess allowed for subsequent contractions. The upright stanchion of the prosthesis appliance, heated in spirits flame, was then inserted upwards into the mould and screwed to the dental splint. Sterile ice water was sprayed through the gum incision causing the mould to set, and it was then removed with the stanchion unscrewed from the splint.

A Thiersch graft, taken from the non-hairy area of the right thigh, cut in one large piece and thin, was spread completely over the mould, raw area uppermost. The skin-covered mould attached to the upright appliance was inserted into the cheek per gingival incision, and secured to the cup-shaped splint attached to the dental plate. The whole appliance was securely held in situ for 10 days by a strong piece of metal, "T" shape, which was attached to the centre of the dental splint by means of a ball and socket joint. The flares of the "T," which were hooked in several places, were attached to hooks on a strong brass headpiece and secured by strong rubber bands. After 10 days, it was removed and cleansed and the cavity gently irrigated.

Inspection of the cavity then showed the formerly raw areas covered with an epithelial lining, grayish white in color. A mould of guttapercha, patterned after the original one of Stent, was inserted into the

cavity to take the place of that removed. It was removed several times daily for



some weeks for cleansing purposes and to prevent contractions.

The patient was discharged from the hospital as cured, as she salivated through the mouth, and the headaches had disappeared. Examination on March 26, three month's after operation, shows an epithelized surface with normal mouth salivation. There still remains an antral opening which I propose to close by utilizing a flap taken from the palate.

First Lying-In Hospital.—The first evidence of any specific provision for lying-in women occurs in the proposal of the Westminster Charitable Society, which in 1716 launched a scheme for the lodging, maintenance, and treatment of poor lying-in women in the parish of St. Margaret. In 1734 St. George's opened its doors: but lying-in women were specifically excluded. But eighteen months after its foundation, suggestion was considered by the governors of St. George's for setting aside one ward for lying-in women, to receive twenty-five cases. The project, however, did not mature. In July, 1747, special wards on a separate floor were set aside at the Middlesex for married lying-in women, followed in 1749 by the establishment of the Lying-In Hospital in Brownlow Street, Holborn, and in 1750 by the City of London Lying-In Hospital in Aldersgate Street. But these likewise were for married women only.—Peachey: Proc. Roy. Soc. Med.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:
14 SOUTH DAY STREET, ORANGE, N. J.
Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:
CHAS. D. BENNETT, M. D., Chm., 750 Broad Street, Newark.

EDITOR:
HENRY O. REIK, M.D., F.A.C.S.

ASSOCIATE EDITORS:
CHRISTOPHER C. BELING, M.D., Newark
HENRY B. COSTILL, M.D., Trenton
JAMES HUNTER, JR., M.D., Westville
HARRISON S. MARTLAND, M.D., Newark
FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

Pending further arrangements, all communications, including manuscript, should be addressed to Dr. C. D. Bennett, 750 Broad Street, Newark, N. J.

In Memoriam.

Resolutions adopted by the Board of Trustees of the Medical Society of New Jersey, upon the death of Dr. David Combs English:

In the death of David Combs English, at his home in New Brunswick, N. J., September 19, 1924, in his eighty-third year, the Trustees and Members of the Medical Society of New Jersey have sustained an irreparable loss. For more than fifty years, covering one-third of the lifetime of the Medical Society of New Jersey, his counsel, his guiding hand, his fine principles and noble character, his lofty medical ethics and his keen sense of the power of organized medicine, have been indelibly written in the history of our venerable society.

For many years a leader in the councils of his Church, in the medical societies of his native city and county, his worth to

the community at large was soon felt, and he was called to the larger field of President of the New Jersey Sanitary Association, President of the Medical Society of New Jersey, 1897-98, a Trustee of the Society from 1898 up to the time of his death, and Editor of the State Medical Journal for nearly twenty years. After his retirement from active practice many years ago, he practically lived for the Medical Society of New Jersey.

Among his many striking characteristics were his cheery optimism, his undaunted courage and his great capacity for work, even after his eightieth year. He took an active part in all our deliberations, our committees' work, our County Society meetings, our Welfare and Legislative programmes, up to the very week of his death.

The members of the Board of Trustees, with whom he had been closely associated for over twenty years, feel deeply and keenly the sense of personal loss in the passing of this worthy honored friend.

Resolved that these resolutions be spread upon our minutes, a copy sent to the Journal for publication, and a copy forwarded to the bereaved family.

Signed, for the Trustees, by
W. G. Schauffler, M. D.
J. B. Morrison, M. D.

CIRCUMSTANCES ATTENDING THE ILLNESS OF THE LATE DR. DAVID C. ENGLISH.

The Journal Staff has been receiving many inquiries from all over the country regarding the last illness of our departed friend and editor, Dr. David C. English, and the rumor seems to have gained strength that he was injured by an automobile. This, however, is a mistake, and it appears advisable to now give the facts, as we know them, and so to make clear to his numerous friends just what really happened.

Dr. English had been spending his vacation at Harrison, Maine, the birthplace and old home of Mrs. English, and returned to New Jersey to complete his editorial work on the September issue of the Journal. This accomplished, he again set off for Maine and nearing his destination heard the train conductor call out a station which he thought was his. Leaving the train, he found he was mistaken and hurrying along the platform to again reach his car, stumbled over a suitcase on the platform, falling and injuring his knee so badly that he had to be carried on the train.

Finally reaching Harrison, he was taken to his hotel and put to bed, where he remained for about three weeks. The diagnosis of his physician was a torn internal ligament of the right knee joint.

He was brought to his New Brunswick home about the middle of September and was seen by his own physician on September 16th, who found him in bed but complaining of nothing except the inability to use his right leg without a great deal of pain.

Careful examination revealed no evidence of illness except the local joint trouble and he seemed otherwise in his customary good health.

The next evening his physician was summoned and found him suffering with severe abdominal distress—he himself calling it intestinal indigestion. But he was breathing rapidly, coughing a little, had a pulse rate of 120 and there were edematous rales at the base of both lungs. Abdominal examination revealed nothing and the temperature was normal. Stimulation by digitalin relieved him and the next day he seemed better, the abdominal distress was almost gone, there was less dyspnea and pulse rate had fallen to 100. The edema at the bases of the lungs was however still present.

The next evening the abdominal discomfort returned with no especial disturbance of heart action or of respiration. No valvular cardiac signs could be noted.

At one o'clock the next morning, his physician was excitedly called by Mrs. English to come at once, as the doctor was very ill and would be dead before he got there if he did not hurry. Actually he had passed away when the physician arrived.

The diagnosis was a coronary thrombosis, probably correct, as there was well marked arteriosclerosis of the peripheral arteries with a blood pressure of 160 mm. systolic. Apparently the shock to his system from the fall and the subsequent pain and loss of sleep with the necessity of lying in bed for three weeks completely upset the circulatory balance and while the injury was not the direct cause of death, it certainly started the trouble and inaugurated a sequence of physical failure which could not be overcome and which finally proved fatal.

The funeral services were held in the doctor's old church and were attended by a large number of physicians from all over the State and the remains were taken to Harrison, Maine, for interment.

THE NEW EDITOR.

At a meeting of the Board of Trustees of the Medical Society of New Jersey, held at the Academy of Medicine, Newark, N. J., October 1, 1924, after a thorough discussion of the merits of the different candidates, the Trustees tendered the position of Editor of our Journal, Secretary of the Welfare Committee and Publicity Agent for the Society to Dr. Henry O. Reik, former president of the American Institute of Medicine and Editor of the International Medical and Surgical Survey.

The Recording Secretary of the Society, Dr. Morrison, had searched the field most thoroughly for the right man for the position. After eliminating all but two of the candidates, the Board of Trustees decided in favor of Dr. Reik, whose past record gave every evidence of excellent qualifications for the work involved in the triple positions to which he was elected.

Dr. Reik comes to us with an unusual record of medical activities. He is a graduate in both medicine and pharmacy, successively Instructor and Associate in Ophthalmology and Otology at Johns Hopkins, and later Editor of the Bulletin of the Medical and Chirurgical Faculty of Maryland as well as of the International Medical and Surgical Survey.

Under the direction of the American Medical Association, he was active in reorganizing the County Societies of the State of Maryland.

He also participated in the organization of three Maryland hospitals and later became the organizer and executive secretary of the New York Association for Medical Education.

His work has made him familiar with all the medical journals published in America and on the Continent.

Dr. Reik is a member of all the Ophthalmological Societies, the A. M. A., and the American College of Surgeons.

Volunteering for work in the World War, he entered as a Captain and retired with the rank of Lieutenant Colonel, and he has recently been promoted to the rank of Colonel in the Medical Reserve Corps, U. S. Army.

Three medical books and a work for the laity on the Safeguarding of the Special Senses are the result of his pen.

As a platform lecturer and speaker, he is able and efficient, not alone in medicine but also upon the subjects of travel and art.

These are a few of his qualifications for the position to which he has been elected by your Board of Trustees, who bespeak for him the earnest co-operation of the County Societies throughout the State. It is the hope of the Trustees that the coming of Dr. Reik will mean a new era in the history of the State Society, its Journal, the work of its Welfare Committee and a better understanding upon the part of the public as to our attitude as a Medical Society upon all questions affecting the health and hygiene of the community.

James Hunter, Jr.,
Secretary, Board of Trustees.

A WORD FROM THE EDITOR.

To the Members of the Medical Society of New Jersey:

In accepting the editorship of your Journal, I am not unmindful of the size of the task assumed nor of the responsibilities involved. In the first place, it will be no easy matter to continue the work and maintain the high standards set by my predecessor, the late Dr. English, and if at the end of my period of service I shall have earned even a moderate portion of the esteem in which his memory is held my labors will not have been in vain.

The Journal ranks high among the State Society Journals of the country. It will be my endeavor to keep it in such a position, and to that end I request your helpful aid and constant support. Few things are so good that they cannot be improved. In the further growth and development of this Journal let us strive for a steady improvement. Advancement will not, however, depend solely upon the labor of the Editor; if the character of the Journal is to be sustained and the quality of its output is to be improved, your help is essential. So, I ask for your active assistance, individually as well as collectively.

In large measure I am a stranger among you, possessed of far too little knowledge of the past history of your Society, but I come to you without any prejudices whatsoever, ready to work with you in developing the plans which I understand you have formulated in recent deliberations, and animated by the sole desire of helping to promote the interests and welfare of the medical profession of this state. You have received me very cordially; I promise to devote my best efforts to this work.

Henry O. Reik, M. D.

THE PRESIDENTIAL ADDRESS.

The annual Address of the President, delivered this year by Dr. Wells P. Eagleton, at the Atlantic City meeting of the State Society, and published in this issue of the Journal, is something out of the ordinary. If you were not so fortunate as to have heard it as delivered so impressively by President Eagleton, you should embrace the opportunity now of reading it in its entirety. To each and every member of the New Jersey State Medical Society it is, in effect, a "clarion call" to duty. A great work has been inaugurated and the way has been indicated for the future development of the Society's activities.

The Board of Trustees, accepting the first recommendation of the President, has taken the initial step in the plan for an organized procedure, by appointing an executive secretary to devote his time and energy to the promotion of the Journal and the development of an educational campaign within and without the professional ranks. You are invited to remember, however, that this is but the first step toward accomplishment of the large task in hand; that "organization" contemplates something more than the mere appointment of an executive officer; that it implies co-ordination of all the elements available and the co-operation of every member of every county medical society in the state—not alone sympathetic co-operation expressed in words, but active co-operation in the form of supporting deeds.

If the larger things desired by the Society are to be effected, individual members must give their hearty assistance to the officers and committees elected or appointed from time to time to look after details of the plan. Read the Address, see why your help is required, and be ready to render that help when called for.

THE NEW JERSEY PRESS ASSOCIATION.

At a recent meeting of the New Jersey Press Association, held in New Brunswick, September 30, 1924, Dr. J. Bennett Morrison, Secretary of the Medical Society of New Jersey, was invited to speak on matters of public import in which the medical profession might be interested. Dr. Morrison spoke briefly in explanation of our position with regard to legal requirements that those desiring to practice medicine should present evidence of having acquired a satisfactory preliminary education and of

establishing suitable standards for those who would offer their services, as physicians, to the public. At some length, he outlined the program of the State Medical Society for education of the public in matters pertaining to health, hygiene and the dangers of communicative diseases.

Dr. Morrison made reference, particularly, to the action of the press in relation to malpractice suits, showing how the reputation of a physician or dentist may be ruined by the publication of false or inexact statements, how suits may be entered merely for black-mailing purposes and without intention ever to bring them to trial, and the injury that results from giving publicity to these baseless procedures, and he asked that representatives of the press refrain from publishing alleged information regarding these malpractice cases until they have actually reached the court calendar. Thereupon, the President of the Association pledged to the medical profession the active and hearty support of his organization.

THE GENERAL PRACTITIONER.

In these days of rather reckless criticism of old established principles and customs and practices, when even physicians occasionally show evidence of a lack of deep thinking by their unjustifiable strictures upon the profession, it is a pleasant experience to run across such a sane and healthy editorial in the lay press as the one here presented from the New York Times of October 16, 1924.

Dr. Vincent is one of the foremost public speakers of the age, and he never speaks thoughtlessly; his pronouncements are always the result of careful study and his deductions and conclusions are drawn from ascertained facts. The New York Times is the leading newspaper of the country, careful as to the accuracy of the news it publishes, and more than careful as to opinions it expresses editorially. The medical profession, the general practitioner in particular, would not have received such praise from this noted educator and publicist if it had not been deserved; and, the fact that the Times picked out that address and made it the subject of a special editorial, speaks well for the public standing of the physician.

In rejoicing over this tribute to the general practitioner of the past, let us not, however, overlook the fact that Dr. Vincent offers a number of important suggestions as to what we shall do to merit continuance of the good opinion in which the profession

has been held. Many of these suggestions are directly in line with our policy in relation to further improvement in professional work and the better education of the public on medical matters.

"THE DOCTOR OF THE FUTURE."

(Editorial, N. Y. Times, Oct. 16, 1924).

No figure in the life of country districts and smaller communities has more endeared himself than the "doctor of the old school." The Weelum McClure of Ian MacClaren's stories has had many living counterparts in America—the general practitioner at his best, resourceful, a friend and counselor as well as a physician. Seventy-five per cent. of our population are still treated by general practitioners with limited technical appliances, little or no specialization of skill, and but a slight relation to medical services organized in hospitals, dispensaries and clinics. This is the estimate of Dr. George E. Vincent, President of the Rockefeller Foundation, who spoke in Kansas City at the second annual meeting of the American Child Health Association. He said that the problem of the American doctor of the future comes largely down to this: "Can the general practitioner be reproduced on a high level of efficiency and can he survive under the conditions which he is likely to face?"

Many assert that his opportunities are being constantly restricted so that he will not hereafter be able to gain social esteem or even earn a livelihood. Dr. Vincent's answer is that the underlying American philosophy of individualism finds embodiment in the general practitioner and will not let him go. It will still have need of him as a "counselor of health." Even after environment has been "sanitized" and communicable diseases have been subjected to public control and become rare, as, for example, typhoid fever in some areas; even though the specialist has pre-empted certain anatomic territories and pathogenic states, and the growth of institutional and preventive medicine has encroached upon the fields of curative medicine, there still remains a need for the general practitioner which no specialist or hospital can fully satisfy. He is characterized by Dr. Vincent in this way:

"The well-trained, properly equipped, experienced general practitioner of ability, character, personality is a fundamentally valuable person. He is a good diagnostician. He sees his patient as a whole. He knows his peculiarities and circumstances. He can decide when to refer him to a specialist and when to protect him against the very real danger which is threatened by a narrowly specialist point of view."

He may hope to survive only if he will "submit to a measure of organization and team-play in the co-operative use of laboratories and other resources," and especially if he will become a "practitioner of preventive medicine." To this end he will need a different sort of training and must assume a different attitude. He must give more attention to diet, exercise, mental attitudes, recreation, family and social life. His chief function will be that of **trying to keep his patients in health** and of knowing where to send them in case of accident or illness. This, of course, will require

a change in the people also, for they must come to think of keeping their physical and mental machines in order, instead of awaiting break-downs and blow-outs and then making belated and expensive repairs. The day may come, says Dr. Vincent, when men will treat their bodies almost as wisely as they do their motor cars.

County Society Proceedings

BERGEN COUNTY.

Flora Adams, M. D., Reporter.

The annual meeting of the County Society was held at Hackensack on Tuesday, October 14, 1924, under the presidency of Dr. George I. Edwards. The following named officers were elected for the ensuing year: President: Herman Trossbach, of Bogota. Vice-President: M. T. Sullivan, Englewood. Secretary: C. N. Dexter, Englewood. Treasurer: W. T. Webb, Hackensack. Permanent Delegates: George I. Edwards, Bogota; A. W. Ward, Demarest; S. T. Hubbard, Hackensack. Annual Delegates: George W. Finke, Hackensack; C. H. Knox, Ridgefield Park; David Corn, Ridgefield Park. Nominating Committee: C. H. Knox, A. W. Ward and C. A. King. Welfare Committee: H. M. Cooper, Valentine Ruch and Joseph Payne. Legislative and Public Health Committee: J. F. Bell, Englewood; J. R. Morrow, Oradell; S. E. Armstrong, Rutherford; Chas. F. Adams, Hackensack; Frank Freeland, Hackensack. Committee on Admission: P. E. Brundage, A. A. Sawyze and Paul O'Brien. Entertainment Committee: Ralph Gilady, C. A. Connor and E. P. Es-sertier. Scientific Committee: G. W. Finke, J. F. Bell and G. H. McFadden. State Nominating Committee: George H. McFadden.

Dr. S. E. Armstrong, chairman of a Special Committee to consider the question of commitment of insane persons to institutions, reported that the November meeting of the Society would be devoted to a discussion of the following suggestions: (1) No patient shall be examined for commitment except after a court hearing. (2) No person to be examined in the jail except when under arrest. (3) A recommendation that in so far as investigation of the supposedly insane person is concerned, it should be taken out of the hands of the court and placed in the hands of a commission. (4) That the fee for examination be raised to \$30. (5) The examining physician to receive a fee of \$3 per hour, or any fraction thereof, for time spent at court hearings. (6) An officer or officers to be furnished by the court for protection of physicians when requested.

Dr. Armstrong and his committee invite interested members of other county medical societies to attend the November meeting and hope particularly for representatives from Hudson, Essex and Passaic counties, to take part in the deliberations.

President Donohue of the State Society requested co-operation with the Welfare Committee in its efforts to secure new medical legislation.

Dr. Morrison, Secretary of the State Society, spoke of the growing need for a publicity agent or welfare instructor for public education, and of the consequent necessity for

raising society dues to meet the increased cost of work.

Dr. Ney, of New York City, the guest of the evening, then presented a paper on "Recent Advances in Brain Surgery," illustrated by radiograms taken after injection of air into the ventricles.

September Meeting.

Frederick S. Hallett, M.D., Reporter.

The Bergen County Medical Society resumed its monthly meetings September 9th, at 8.30 P. M., at the Hackensack Hospital. The president, Dr. G. L. Edwards, presided, about 25 members being present.

The following new members were elected: Dr. John Dickson, Bogota; Dr. J. P. Cleary, Westwood.

The paper of the evening was read by Charles F. Adams, A.M., M.D., attending physician, Hackensack Hospital.

Dr. Adams' paper was a little out of the ordinary and proved of much interest to the members present. This paper will be published in the Journal in a future issue.

The Scientific Committee announced that at our next monthly meeting, October 14th, Dr. K. Winfield Ney, New York City, will read a paper on "Recent Advances in Neurologic Surgery," supplemented by lantern slides.

BURLINGTON COUNTY.

Daniel F. Remer, M. D., Reporter.

The annual meeting of the Burlington County Medical Society was held in the Parish House of St. Andrew's Church, Mount Holly, on Wednesday, Oct. 8, 1924, Dr. J. E. Dubell, of Columbus, presiding. The following named officers were elected for the ensuing year: President: Harold E. Longsdorf, Mount Holly. Vice-President: R. I. Downs, Riverside. Secretary and Treasurer: George T. Tracy, Beverly. Censors: Benj. K. Brick, of Marlton, and Frank G. Stroud, Moorestown. Delegates to State Society: Edgar J. Haines, of Medford, and Harry W. Bauer, of Palmyra. Member of Nominating Committee: M. W. Newcombe, Brown's Mills. Reporter: R. I. Downs. Delegate to Camden County Society: Edwin R. Hunter, of Delanco, and Emlin Stokes, Moorestown. Delegates to Atlantic County Society: Ivan N. Keim and Joseph M. Kudder, Mount Holly. Delegates to Cape May County Society: Alexander Marcy, Riverton, and Joseph Stokes, Moorestown. Delegates to Gloucester County Society: M. W. Newcombe, Brown's Mills, and Emlin P. Darlington, New Lisbon. Delegates to Salem County Society: D. H. B. Ulmer, Moorestown, and Harry L. Rogers, Riverton. Chairman Section on Practice of Medicine for April meeting: Emma W. Metger, Riverside. Chairman Section on Surgery, for January meeting: Daniel F. Remer, Mount Holly. Chairman Section on Obstetrics and Pediatrics, for June meeting: Edwin R. Hunter, Delanco.

Dr. Henry O. Reik, the newly elected Editor of the State Journal, visited the society and asked for the co-operation of the County Society in the conduct of his work for the state organization.

Dr. J. E. Dubell, the retiring president, read a very instructive paper on "Blood Pressure."

There were 24 members in attendance, and

after partaking of a splendid dinner served by the ladies of St. Andrew's Guild, the society adjourned, to meet again in Burlington in January.

CAMDEN COUNTY.

Horace L. Rose, M. D., Reporter.

The seventy-eighth annual meeting of the Camden County Medical Society was held at the Camden City Dispensary, on Tuesday, Oct. 14, 1924, the meeting being called to order at 3 P. M. by the president, Dr. J. Edgar Howard. The following named officers were elected to serve for the ensuing year:

President: Charles H. Jennings. Vice-President: Alfred M. Elwell. Secretary: Thomas B. Lee. Assistant Secretary: Joseph E. Roberts. Treasurer: J. E. L. Van Seiver. Reporter: Horace L. Rose. Historian: Daniel Strock. Censor: Henry H. Davis. Trustee: Joseph L. Nicholson. Committee on Scientific Work: A. Haines Lippincott, Edward C. Pechin and George P. Myer. Committee on Arrangements: Ernest G. Hummel, Paul T. Young and Thomas K. Lewis. Delegates to Medical Society of New Jersey: Edgar Clement, I Grafton Sieber, Joseph E. Roberts and Emma Richardson. Delegates to the Atlantic County Society: T. M. Madden, J. J. Haley and Thomas K. Lewis. Delegates to Burlington County: John Marcy, E. W. Rossell and Edward B. Rogers. Delegates to Cape May County: Paul M. Mecray, Leslie H. Ewing and Alexander MacAlister. Delegates to Cumberland County: Horace L. Rose, Grafton E. Day and E. Reed Hirst. Delegates to Gloucester County: Emma Richardson, W. W. Kain and A. L. LeFevre. Delegates to Salem County: William B. Jennings, Ernest R. Hummel and James D. Smith. Nominating Committee of the State Society: A. Haines Lippincott.

The address of the retiring president, Dr. J. Edgar Howard, dealt with the subject of "Arteriosclerosis." (It will be published in full in a later number of the Journal).

The historian of the society, Dr. Daniel Strock, presented his report for the year, as follows:

Historian's Report of Camden County Medical Society for 1924:

The history of the Camden County Medical Society has not been particularly exciting during the past year, and it will not take long to tell the story.

The regular meetings have been held. There have been no special meetings. One member has died; Dr. Lida Taylor Allen DeLuca, of Collingswood. She practiced in that town for 15 years, and had endeared herself by her gentle and pleasing manners, and her devoted attention to her patients. Nearly two years ago, she had a cerebral hemorrhage from which she was partly incapacitated and a subsequent hemorrhage caused her death. A coincidence might be noted here; Dr. George Evans Reading, of Woodbury, died on the same day, of pneumonia. Dr. Reading was a delegate from Gloucester County to this society for a quarter of a century continuously.

History deals with the dead as well as with the living. The services of Dr. Charles S. Braddock, deceased, of Haddonfield, were so much appreciated by King Rama of Siam, a few years ago, that he decorated the doctor

with the Order of The White Elephant, for his great sanitary work in Siam, where through his efforts small-pox was controlled and the ravages of beri beri and cholera suppressed. In appreciation of Dr. Braddock's services King Rama has presented \$500 to the Centennial Committee of Jefferson Medical College. Dr. Braddock returned home from Siam with greatly impaired health and died during the year of 1916.

Mrs. Louisa S. Cook, widow of Dr. Frank B. Cook, of Laurel Springs, remarried last July. Dr. Cook was a victim of the influenza epidemic of 1918.

Heretofore there has been no scarcity of political aspirants from professional ranks; this year finds only one, Dr. Grafton E. Day of Collingswood, who aspires to the position of U. S. Senator and is a candidate on the Prohibition ticket.

Dr. Edward B. Rogers, formerly Major in the U. S. Medical Reserve Corps, was recently promoted to the rank of Lieutenant Colonel.

Early in the year this headline appeared in our daily papers: "Health Officer Fired by Rulers Hold His Place." Which meant that Dr. John F. Leavitt, for more than twenty five years medical inspector of the Board of Health, was slated to go, but the discharge was reconsidered by our new city officials and he has been retained in that office with enlarged powers. Dr. Leavitt has been a very efficient health officer, most courteous and kind to physicians and laity.

Dr. Henry H. Davis has been honored by having the new school building at Twenty-sixth and High Sts. named for him; a great and enduring monument. For twenty-five years, Dr. Davis has been chief medical inspector for the Board of Education of Camden.

Dr. Howard F. Palm took his usual vacation in the far West, visiting all the places of interest between here and the Pacific Coast.

Dr. Lettie Allen Ward has sold her property at 613 Cooper St. to make way for the new hotel and has purchased 325 Cooper St., where she will live and practice.

Dr. Thomas K. Lewis and Dr. B. F. Buzby have opened offices at 414 Cooper St., in the building with Dr. Earnest G. Hummel.

Dr. Joseph E. Roberts has purchased a residence at Haddonfield; he will still retain his offices at Fourth and Cooper Sts.

Dr. Paul Mecray has acquired a property in Moorestown, and has moved his family there.

Dr. Fred C. Becker has purchased the property at 620 Benson St.; where he will live and practice. He has recently been appointed Neurologist to the State Rehabilitation Clinic.

Dr. Alex. MacAlister has recently returned from an extensive tour of Europe.

Dr. A. Haines Lippincott was recently elected a Fellow in the American College of Surgeons.

Dr. Wilson G. Bailey has but recently returned from Europe; having spent the past eight months there.

Dr. Charles S. Jennings, our newly elected president, and Mrs. Jennings, spent the summer at Sea Side Park. They will spend the winter at Miami, Florida.

Dr. Adrianette L. LeFevre, of Blackwood and Dr. Emma Richardson spent the past winter in Florida, in pleasant companionship.

The society then adjourned to the adjoining room, where a very enjoyable dinner was served.

CAPE MAY COUNTY.

Eugene Way, M.D., Reporter.

The forty-first annual meeting of the Cape May County Medical Society was held at the Hotel Bellevue, Cape May Court House, on Tuesday, October 14, 1924, Dr. Charles M. Gandy presiding. There was a good attendance and the reports of committees indicated that the past year had been one of progress. The following officers were elected: President, Charles M. Gandy. Vice-President: George M. Dandois. Secretary and Reporter: Eugene Way. Treasurer: H. H. Tomlin. Delegates to State Society: Clarence W. Way and Millard Cryder. Committee on Public Health Legislation and Welfare: Julius Way, V. M. D. Macey and W. L. Lake.

Dr. Julius Way reported for the Hospital Committee that the county needs a welfare home with hospital accommodations, but that some additional legislation will be required before the project can be satisfactorily advanced.

Mrs. Hazzard of Ocean City addressed the society on the newly established "Seashore Home for Babies, at Ocean City, and was assured the support of the society in its maintenance.

Dr. W. P. Glendon of Bridgeton delivered an address on "Cancer," referring particularly to the less frequent use of surgery and the more frequent employment of radium in the treatment of this condition, relating several remarkable cases.

Dr. R. R. Chadsworth, of Wildwood, was elected to membership.

CUMBERLAND COUNTY.

E. S. Corson, M.D., Reporter.

The annual meeting of the Cumberland County Medical Society was held at the Cumberland Hotel, Bridgeton, Tuesday, October 7, 1924, with the President, Dr. Percy Lummis, in the chair. The following officers were elected for the new year: President: E. C. Lyon, of Bridgeton. Vice-President: H. S. Branin, Millville. Secretary: H. G. Miller, Millville. Treasurer: H. H. Wilson, Bridgeton. Reporter: E. S. Corson, Bridgeton. Censor: L. J. Kauffmann, Millville.

Drs. R. D. Clippinger and H. S. Foltz, of Vineland, were elected to membership.

The following resolution was presented by a special committee, consisting of Drs. M. F. Sewall and E. S. Corson, and duly adopted: "The Cumberland County Medical Society desires to place on record an appreciation of its loss by death of Dr. W. Leslie Cornwell. He was a valued member and for a long time the efficient treasurer of the society. He was untiring in his efforts to advance the welfare of the medical profession. His record of service in the World War is one of which the society is duly proud. His interest in the sanitary welfare of the community was ever manifest. His congenial personality has left undying memories in our hearts."

Dr. Harry Brown, of Freehold, read an interesting paper on "Immunization Against Diphtheria." Dr. Eldridge Eliason, of the

University of Pennsylvania, read a paper on "Chauffer's Fracture, of the Wrist and Arm," illustrating his talk with lantern slides.

Representatives from the Salem and Gloucester County Societies were present. The Board of Managers of the Newcomb Memorial Hospital, Vineland, extended the society an invitation to hold its January meeting in the hospital and the invitation was accepted.

HUDSON COUNTY MEDICAL SOCIETY.

Wm. Freile, M.D., F.A.C.S., Reporter.

The first meeting of the season was called to order at 8:30 P. M., October 7, 1924, at Auditorium, Jersey City Hospital.

Victor C. Pederson, M.D., (author of "Pederson's Urology") was the speaker of the evening, and gave an informal, practical, meaty and interesting talk (with lantern slide demonstration) on "Unusual and Difficult Urologic Cases." He cited many cases, among them a sarcoma of the kidney in a child, with general metastases seven months after removal.

In speaking of teratoma testis, he advised to cut high up and stressed the need for gentle manipulation in examination for diagnosis; the same thing applied to tumors of the breast, as in malignancies, rough handling promptly disseminated the disease to the adjacent glands. He showed various slides demonstrating the pathology of these teratoma, including one case operated on ten years ago, still alive and well, and mentioned that Dr. O'Crowley, of Newark, who for some reason has had a good many of these cases, considered it was remarkable to have a patient live over three years.

He exhibited and talked of several slides on stones in the ureter and cited the difficulties in diagnosis in some of the obscure conditions, as where the ureter is enlarged and draining and, therefore, not giving the classical symptoms; as where piles developed from pressure, which throws suspicion on the sacrum or rectum.

He referred to the trouble caused by "know it all relatives" and detailed a case where a daughter overheard a doctor's remark in reference to removing her mother's kidney; the girl talked her mother into a refusal of operation and she died of a condition which at the time of consultation was amenable to surgical treatment.

Dr. Stanley R. Woodruff, in opening the discussing, stated that he was of the belief the ordinary surgical treatment of bladder tumors was very poor, particularly when an attempt is made to remove growths in the later stages. He regarded every bladder tumor as potentially malignant, and the destruction of them by high frequency is very apt to be followed by recurrences, which however are not any more potentially malignant than the primary growth. These cases should have systematic examination two or three times a year for the rest of their lives.

He referred to the absorptive power of the mucous membrane of the lower ureter, the danger of its infection and also of the kidney from too much manipulative work, and when a case did not get along fairly fast he advocated open operation.

Dr. Daly referred to the need for cooperation

between the general practitioner and urologist, as often symptoms of venereal diseases were mild and misleading. This attitude was also taken by Dr. Joseph Koppel.

Further discussion of the talk was carried on by Drs. Louis Franklin, Joseph Rector and George E. McLaughlin. The latter spoke on the pathogenesis of calculi in general, after which Dr. Pederson closed, referring to electro-therapeutics (he being president of The Electro-Therapeutic Society) and stated his views on dosage, distance, etc., and advocated radium or x-ray before and after operation for malignancies, in safe dosages.

The Nominating Committee reported and the following officers were elected:

President, Dr. E. J. Luippold, Weehawken; Vice-president, Dr. Joseph F. Londrigan, Hoboken; Treasurer, Dr. H. H. Brinkerhoff, Jersey City; Secretary, Dr. Wm. L. Yeaton, Hoboken; Reporter, Dr. Wm. Freile, Jersey City.

Dr. Charles B. Kelley, retiring president, in a talk entitled "Last Year and This," referred to the temerity with which he had accepted the office, but felt that the society had made progress. He referred to the good attendance, even when adverse weather conditions existed. He had welcomed constructive criticism. He was of the opinion that an out of town speaker always got more attention than a local man. The society had added 48 new members during the year, and the treasurer had been able to report paid up names totalling 327 as of February 1924 (and 49 old members failed to pay). This represents about 80% of available timber. There are presumably about 100 physicians scattered throughout North Hudson, Bayonne, West Hoboken and Hoboken, non-members.

Hoboken is nearly 100% paid up but extremely inactive. In view of this it is particularly interesting that a man from the mile square city has been selected for vice-president.

He praised Drs. Luippold, Woodruff, and Londrigan for their conduct of the most successful dinner, even financially. He referred to the amount of work necessary in publishing "The Bulletin" and advocated the employment of a part time secretary.

It was to be regretted that the move to establish an academy or home for the society had failed, and particularly so as it eliminated the memorial to Dr. Faison.

The society had recently lost by deaths Drs. Cravin, Broderick, Lampson and Mooney, the latter the speaker paid a tribute to as a good and kind friend. The Hudson County Medical Society had been favored in the election of our genial Lucius F. Donohue to the presidency of the State Society, and he bespoke for the newly elected officers the co-operation of the members.

Dr. Luippold, the incoming president, expressed himself as being deeply honored, and hoping to see a friendly revival of good feeling between the various sections comprising the society, and he advocated (inasmuch as the county society was now incorporated) that the Board of Trustees, together with all the officers of the organization meet frequently and discuss measures leading to effective work.

Dr. George E. McLaughlin, city bacteriologist, spoke on the use of Chlorine in Affections

of the Respiratory Tract. He had been for many years interested in chlorine, and as the result of his researches, Jersey City was one of the first cities in the world to adopt the chlorine treatment of its water supply. He had been detailed in 1917 by the Navy Department of the Rockefeller Institute, to work with Drs. Carrel and Cullen in making the Carrel-Dakin solution in which chlorine is used. During the influenza epidemic of 1918, it was noticed that the men associated with this work, although young, did not go down with the disease, although so many thousands of similar age died.

The speaker then cited several cases where chlorine had been used with benefit, went into the question of dosage and had the machine for generating the gas demonstrated.

Dr. Lucius F. Donohue, first Vice-president of the State Society expressed his pleasure in visiting officially one of the component societies. He gave a resume of the activities of Dr. English, Editor of the Journal of the Medical Society of New Jersey, who had passed to his reward during the last month; eulogized his unselfishness, deplored his loss, and showed the difficulty of filling his place, even with substantial remuneration offered.

He referred to the tremendous showing made last year at Trenton by the chiros and the sparse representation of medical men. He advocated more representation from the legislators and better laws to protect doctors from blackmailing. He recalled the amount of time and energy that Dr. Quigley had given to the Welfare Committee, and regretted that circumstances prevented him this year from devoting his zeal to the same extent as last year.

He regarded Dr. Pinneo as one of the most active members in Welfare work.

Dr. Samuel A. Cosgrove, reporting on the projected Hudson County Maternity Hospital, said it had been a big objective of our leaders for a number of years, and that at the last session of the legislature an enabling act had been passed. A site at Webster Avenue and North Street (geographically the center of the county) abutting on a plot which the County has secured for a park, has been selected, and will be suggested to the Board of Freeholders as the most suitable situation.

Dr. Cosgrove then discussed the question of beds in ratio to present population, and to the presumptive annual increase. He stated that while the needy would be taken care of, there was no intention to pauperize the white collar man to help him, and likewise to cater to those who had means to pay for the best. Likewise there would be no pauperization of the medical profession, as the profession would be admitted to the institution to take care of their personal cases, subject to only such general regulations, as will serve the type of work and the interest of the public, and maintain the relationship of paying patient to the physician.

Dr. Cosgrove stated that in presenting this project, as he had stated it, to the men who can say whether they will pass it or not, he wanted to feel that the representative men of the profession in the county were behind him, and Dr. Swiney of Bayonne moved and had carried a motion to that effect.

MERCER COUNTY.

A. Dunbar Hutchinson, M.D., Secretary.

The Mercer County Medical Society met at the Stacy-Trent Hotel in Trenton, May 14, 1924, at 8.15 P. M., Dr. A. W. Atkinson presiding. The minutes of the preceding meeting were read and approved. The regular order of business was suspended, to read a letter of invitation from Dr. David F. Weeks, superintendent of the Village of Epileptics, for the society to meet there in May.

Dr. Schafer, of the Schafer Laboratories, Trenton, read a paper on the "Etiology of Cancer," which was followed by a general discussion of the cancer problem, Drs. West, Ackley, Sommer, Scammell, Adams and Atkinson participating.

Drs. O'Rourke, Seitzick and Chianese were elected to membership.

A motion was adopted placing the society on record as instructing the Nominating Committee to support the first vice-president and adhere to the custom in preceding years.

Adjournment was then taken.

June Meeting.

The June meeting of the society was held at 4 P. M. on the eighteenth, in the Graduate College of Princeton University.

Following the reading of the minutes of the previous meeting, several visiting physicians were invited to take part in the proceedings. A vote of thanks was extended to Dean West and Controller Wintringer, through whose courtesy the society had obtained the privilege of meeting and dining within the walls of the Graduate College. Dean West gave an interesting explanation of the method employed in obtaining the materials for the completion of this beautiful building.

Dr. David F. Weeks presented a paper on "The Etiology, Diagnosis and Treatment of Diabetes," and a spirited discussion of this subject followed.

Dinner was served in the Hall to about 80 members and guests.

October Meeting.

The October meeting of the Mercer County Society was held in the City Hall, at Trenton, October 8, 1924, with the president in the chair. The minutes of the preceding meeting were read and approved.

Dr. William G. Schaffler addressed the meeting on the "Problems Confronting the General Practitioner," referring specifically to such matters as minor surgery, expenses attending visits to specialists, quarantine, reporting of venereal diseases, laboratory aids, consultants, obstetric work, attending the patient of the absent physician, and, the responsibility of the physician to himself as regards reading and study, attending society meetings, postgraduate work, and interest in public health matters.

Dr. Costill, in discussing this broad subject, announced that as Director of Public Health he purposed to extend the rural laboratories.

Dr. Bellis referred to general practice as the "backbone" of all medicine and stated the belief that one reason for so many "cults" springing up lay in the fact that too often the general practitioner failed to realize either his responsibilities or his possibilities. Dr. Haggerty suggested the need for further education of the public in regard to the qualifica-

tions of physicians in order that the laity would not be compelled to pick their physicians and specialists at random. Drs. Hawke, Craythorn and Arthur were somewhat severe in their criticism of the "Specialist from Out-of-town" who often preferred to give a rosy prognosis rather than present the facts as they had already been given by the attending family physician. In closing, Dr. Schaffler appealed for closer co-operation among physicians.

Drs. Nathan Swern and Stephen Vaczi were elected to membership. A motion was adopted empowering the usual committee to arrange for the annual banquet meeting. Applications for membership from Drs. A. K. Bowman, of Princeton, and Elston H. Bergen, were read and referred to the membership committee, and the society then adjourned.

PASSAIC COUNTY.

Louis G. Shapiro, Secretary.

The annual meeting of the Passaic County Medical Society was held on Thursday evening, October 9, Dr. John N. Ryan presiding. Thirty-eight members were present and several visitors, among whom were the following officers of the State Society: Dr. Lucius F. Donohoe, Acting President; Dr. J. Bennett Morrison, Secretary, and Dr. Henry O. Reik, the newly appointed Editor of the State Journal.

After introducing the visitors to the society, Dr. Ryan called upon the speaker of the evening, Dr. John J. Moorhead of New York City, who read a paper entitled, "The Treatment of Automobile Accidents"; an excellent analysis of the principles of treatment in traumatic wounds, discussing the prevention of infection, the management of infection once it had developed, and the treatment of fractures. Dr. Moorhead's paper was very well received and caused much discussion and favorable comment.

Dr. Ryan then called upon the State officers to address the society.

Dr. Donohoe gave in brief a summary of what the State Society had been trying to accomplish in the matter of legislation and urged upon the Passaic County Society the need of greater interest on the part of the individual members in the activities of the State Society.

Dr. Morrison spoke to similar effect and added that, hereafter, the State Society will try to accomplish its ends by educating the laity and convincing them of the need for legislation to curb the practice of the cults, etc. To this end, Dr. Reik had been appointed editor of the State Journal and executive officer of the State Society's publicity work.

Dr. Reik outlined his plans for the State Journal and besought the co-operation of the various county societies in his publicity work.

The following officers and delegates were elected for the year of 1925: President: Thomas A. Dingman. First Vice-President: Charles R. Mitchell. Second Vice-President: Orville R. Hagen. Secretary: Louis G. Shapiro. Treasurer: George K. Tweddel.

For member of the Nominating Committee for the State Society, Henry H. Lucas was regularly nominated and elected. For annual delegates: William Veenstra, Abraham Shul-

man, A. M. Schultz, Orville R. Hagen, John S. Van Winkle, Charles J. Murn, Henry H. Brevort and William Dwyer. Member of Board of Censors: John N. Ryan.

Dr. Joseph A. MacLay presented a resolution, on the occasion of the death of Dr. Cyrus Townsend, which was ordered spread in full upon the minutes and a copy thereof was directed to be sent to the widow.

"Whereas, Dr. Cyrus S. Townsend of 113 Paterson Street, Paterson, N. J., a time honored member of the Passaic County Medical Society, has passed away, his loss marks the passing of another of the old school physicians we are so glad to welcome to meetings. Dr. Townsend graduated from Bellevue Hospital Medical College in 1879. He was almost continually located in his office at the same address on Paterson Street, after he located in Paterson. Dr. Townsend was a kindly gentleman, of a retiring disposition, and for those with whom he came in contact he always had a word of good cheer and fellowship.

Therefore, be it Resolved, That the above be spread in full upon our minutes and that a copy be sent to Dr. Townsend's widow.

The meeting then adjourned.

SALEM COUNTY.

William H. James, M. D., Reporter.

The annual meeting of the Salem County Medical Society was held on the afternoon of October 8th, at the Memorial Hospital, Salem, N. J.

The meeting was opened by Dr. Church in the chair. After the routine business was transacted, which included a report from Dr. John F. Smith, the treasurer, the society had the pleasure of having Dr. I. W. Knight from the State Department of Health, who spoke on "Preventive Medicine and Health Examinations." Among other things the doctor said that it was very essential to have the community enlightened to the fact that vaccination, successfully performed, will prevent small pox.

The Schick test against diphtheria, and the Dick test against scarlet fever, although not so positive as vaccination against small pox, will, in time, be a preventive against those dreaded diseases.

At the conclusion of Dr. Knight's address he was given a rising vote of thanks.

This being the annual meeting, the following officers were duly elected: President: Dr. George A. Davis, Elmer. Vice-President: Dr. C. L. Fleming, Pennsgrove. Secretary and Treasurer: Dr. John F. Smith, Salem. Reporter: Dr. Wm. H. James, Pennsville. Censors: Drs. Summerville, Green and James.

Drs. John M. Summerville, Pennsgrove, was elected annual delegate to the State Medical Society.

The society's next meeting will be held at the hospital on the second Wednesday of December, at 2 P. M.

SOMERSET COUNTY.

Dan S. Renner, M.D., Reporter.

The annual meeting of the Somerset County Medical Society was held at the Country Club, Somerville, October 9, 1924. Dr. Philip Embury, president, was in the chair and the rou-

tine business was regularly disposed of. Dr. Edward S. Hawke, District Counselor, and Assemblymen Grover Kipsey and Jacob Klatz, were guests. Dr. Augustus S. Knight, of Pea Pack, was elected a member. Dr. Hawke read a paper on "Nitrous Oxid and Oxygen in Obstetrics."

The following named officers were duly elected: President: Frederick A. Wild. Vice-President: John D. Ten Eyck. Secretary: A. Anderson Lawton. Treasurer: Runkle F. Hege-man. Reporter: Dan S. Renner. Annual Delegate: A. A. Lawton. Censor: Philip Embury.

The meeting was well attended and at the conclusion of business, dinner was served. Interesting addresses were made by the Republican and Democratic candidates for Assemblyman, respectively Grover Kipsey and Jacob Klatz.

UNION COUNTY.

Russell A. Shirrefs, M.D., Reporter.

The annual meeting of the Union County Medical Society was held on the evening of October 8, at the Elks' Clubhouse in Elizabeth, and was largely attended. The election of officers resulted in the selection of: D. R. McElhinney, as President; G. S. Laird, ice-President; F. Steinke, Treasurer; I. Lerman, Secretary, and R. A. Shirrefs, Reporter. Dr. J. S. Green, by reason of his elevation to Vice-President of the State Society, tendered his resignation as permanent delegate—which was accepted, and Dr. J. Reimer was elected in his place. The annual delegates chosen were: G. W. Horre, G. W. Strickland, A. W. Lamy, R. M. Nittoli, J. Reiner, H. Bloch, G. L. Orton and J. Funk; C. A. Brokaw, N. W. Currie, C. H. E. Upham, and J. B. Harrison being named alternates. S. T. Quinn was made a member of the State Nominating Committee, and C. H. Schlichter was the choice for the position of censor.

The treasurer's report showed the comfortable balance of \$1,172. The Visiting Nurses' Association requested that a committee of physicians be appointed to lend aid, counsel and advice should occasion arise; and the Legislative Committee was designated to act in this capacity.

Dr. I. A. Lawrence, whose license to practice medicine was revoked some months ago, made a written appeal for this society to help his efforts for reinstatement. It was decided to grant him a hearing at the meeting to be held in January.

The following physicians were elected to membership: A. S. V. Giglio, Lewis Newman, N. B. Stanton, John L. Meeker, L. D. Henn, Elmer P. Weigel, Charles C. Polk and Ida H. Frohwein.

As evidence of the regard and esteem in which he was held by this society, regret was expressed in the official minutes over the death of Dr. David C. English, who had served so long and capably as Editor of the State Journal.

The Board of Education curtly and abruptly dismissed Dr. Michael Vinciguerra recently as medical supervisor of the Elizabeth public schools. A committee appointed from this society to investigate the matter, assailed the Board's action in a report calling attention to Dr. Vinciguerra's excellent and constructive

program for the schools, together with the great amount of time that he had given to this work. The medical committee went on record as feeling that Dr. Vinciguerra's work as medical supervisor of the schools was of an excellent, high character; that the program he submitted was constructive and progressive; and that he administered the office in the face of many difficulties and obstacles, in a manner that was highly satisfactory and in conformity with his professional ability and standing. Our committee was convinced that he was dismissed without just cause; and their report was unanimously adopted.

A paper on "Sinusitis in Children" was read by Dr. G. W. Strickland, the retiring president, and was discussed by Drs. Wilson, Schlichter, Reiner and Griesemer.

WARREN COUNTY.

Floyd A. Shimer, M.D., Reporter.

The annual meeting of the Warren County Medical Society was held at the Belvidere Hotel, Belvidere, N. J., October 21, 1924, the president, Dr. Arthur C. Zuck, in the chair.

Election of officers for the coming year resulted in choice of the following: President: Charles H. Lyon, of Phillipsburg. Vice-President: Lawrence H. Bloom, of Phillipsburg. Secretary: L. C. Osmun, Hackettstown. Treasurer: G. W. Cummins, Belvidere. Reporter: F. A. Shimer, Phillipsburg. Delegate to State Society: William J. Burd, Belvidere. Alternate: Willaim Kline, of Phillipsburg, Censor: E. P. Lefferts, Belvidere. Dr. T. S. Dedrich, of Washington, was re-elected to represent the society on the Welfare Committee of the State Society. Col. George H. Bloom, of Phillipsburg, sat as a corresponding member during the meeting. Drs. Leon Hackett, of Washington, and T. H. Spillane, of Phillipsburg, were elected to membership.

The president having announced that the society would reach the centennial of its existence in 1925, the society voted to begin arrangements for the proper celebration of this 100th anniversary and, upon authorization, the following committee was appointed by the chair: C. B. Smith, of Washington, as Chairman; W. C. Burd, of Belvidere, Secretary; L. C. Osmun, Hackettstown, W. C. Allen Blairstown, and William Kline, of Phillipsburg.

Dr. J. Clarence Keeler, Professor of Otology, Jefferson Medical College, read a paper on "Acute Otitis Media; From the Standpoint of the General Practitioner," and the discussion that followed was participated in by nearly every member present.

Dr. Henry O. Reik, Editor of the Journal of the State Society, was present as a visitor, and gave an interesting talk about his work for the organization.

Public Health Items.

New Methods for Prevention of Scarlet Fever and Measles.

(Reported by Dr. Chas. V. Craster.)

At the annual meeting of the New Jersey Health Officers' Association held at the Academy of Medicine, Newark, on September 18, 1924, a very excellent program was presented in which two important preventive measures

were discussed, the new Dick test for the reaction of scarlet fever susceptibility, and the use of measles convalescent serum as a preventive against measles infection. Invitations had been sent out to all health officials and physicians and nurses throughout the State of New Jersey and the attendance was in the neighborhood of 300.

The Dick test was explained by Dr. Abraham Zingher, Assistant Director, Bureau of Laboratories, Department of Health, City of New York. The speaker outlined the principals of the Dick test and by a series of lantern slides explained the reaction, the result obtained and the method of procedure. Dr. Zingher showed very conclusively that in the Dick test we have a complimentary reaction which shows susceptibility to scarlet fever by means of a cutaneous reaction in a similar way to the Schick test for the determination of diphtheria susceptibility. The lecturer explained that in the Dick test there had been developed a specific test which showed the individual susceptibility to scarlet fever and to nothing else. The method employed was the hypodermic injection of small quantities of a killed vaccine of the *Streptococcus hemolyticus*. It was also indicated by the speaker that as suspects to diphtheria could be immunized against the disease by the toxin-antotoxin mixture, so in the Dick test the individual could be immunized against scarlet fever by injection of graded quantities of streptococcus vaccine. For the purpose of the demonstration Dr. Zingher visited St. Mary's Orphanage in Newark and gave the Dick test for scarlet fever to 272 children of all ages.

Among these, 26 (10.5%) gave positive reactions to this test and 89.5% gave negative reactions. A Schick test which was done at the same time for 70 of the children gave 56 negatives and 14 positives; 40 of these children were brought to the Academy of Medicine and shown to the audience. The specific nature of the Dick test was shown by the fact that in some cases Schick and Dick tests were positive or negative, alternately. Some children showed a positive Dick with a negative Schick test, and others a positive Schick and a negative Dick test. In each case a control of normal serum was made at the same time. Dr. Zingher demonstrated the ease with which the Dick test could be performed and predicted the possibility of susceptible children being immunized wherever there was danger of the spread of scarlet fever.

Dr. Roland G. Freeman, attending physician of Willard Parker Hospital, lectured upon the use of measles convalescent serum as a routine prophylactic in this disease. He stated that during the past year 1,500 institutional children and 800 private cases had been injected with varying doses of the convalescent serum, beginning with an initial dose of 3 c.c. It was found that the protection afforded corresponded with the amount of convalescent serum used. With 3 c.c., 70% of the cases were fully immunized; with 4 c.c., 87%; with 5 c.c., 90% showed complete immunity; but, so far, no amount of the serum has given immunity in 100% of cases. Dr. Freeman stated that the immunity lasted from three to six weeks. The chief drawback to the use of this serum is the short supply obtainable, partly due, he stated, to the reluctance on the part of parents to have their children used

for its production, and measles in adults being comparatively rare. He suggested that if every physician equipped himself with some simple apparatus for obtaining the blood of recovered cases he would have sufficient serum in his possession to use in the course of his practice. Dr. Freeman further stated that even in cases where the disease is developed, modification of the symptoms could take place by the use of this serum.

Dr. Henry B. Costill Appointed Director of Health.

The State Department of Health on September 16 appointed Dr. Henry B. Costill Director of Health, to take office on October 1, 1924, when Dr. Price has asked to be relieved of his duties as director. Dr. Costill is a past President of the State Medical Society; a former member of the State Board of Medical Examiners; and during the war had supervision over the Medical Advisory Board of the State.

Bonnie Burn Sanatorium.—Dr. John E. Runnells, superintendent, reports as follows: On August 31st there were 239 patients in the Sanatorium, 134 males and 105 females. This included 77 children in the preventorium. Since the last report 17 patients have been admitted, 12 males and 5 females. Six of these admissions went to the preventorium. The admissions are classified as follows: Pretubercular, 6; incipient 1; moderately advanced, 3; far advanced 7. Total, 60. The largest number of patients present at any time during the month has been 236. Smallest number, 227. Present September 25th, 228. This number includes 73 children in the preventorium and 76 out of the county patients. The following shows the condition of patients discharged during the month: Not considered, 143; apparently arrested, 1; quiescent, 4; improved, 14; unimproved, 4. Total, 28.

Deaths.

BOGARDUS.—Dr. Henry J. Bogardus, of 417 Bergen Street, Jersey City, died suddenly in his office on the morning of October twenty-first. Dr. Bogardus was sixty-six years of age, and death was due to heart failure. He was a graduate of Rutgers College and obtained his medical degree from the College of Physicians and Surgeons of New York; he was an active member of the staffs of the Jersey City Hospital, Christ's Hospital and Bayonne Hospital, and was Senior Physician to the New York Orthopedic Hospital.

FOX.—At Atlantic City, N. J., September 3rd, 1923, Muriel Carroll, wife of Dr. William W. Fox, and daughter of James T. and Maud D. Carroll.

Headquarters 303rd Medical Regiment
Office of the Commanding Officer,
126 Clinton Ave., Newark, N. J.

August 5, 1924.

General Orders
No. 1.

It is with deep regret that the announcement is made of the death of Major Peter P. Rafferty, Med-O.R.C., of Red Bank, N. J., July 20, 1924.

Major Rafferty was commissioned as a First Lieutenant Medical Corps, New Jersey National Guard, in 1909 and was promoted to Captain in 1913. He organized Ambulance Company No. 1, N.J.N.G., and commanded the organization on the Mexican Border, at Douglas, Arizona, in 1916. The efficiency of this unit caused its selection to represent the State of New Jersey in the 42nd Division in 1917. He served with this organization at Camp Mills, N. Y., and in the A.E.F. from August 1, 1917, to January 9, 1918. From January 10, 1918, to March 3, 1919, Captain Rafferty served at the Army Sanitary School, A. E. F., as commander of Ambulance Co. No. 165, 42nd Division, and Field Hospital No. 167, A.E.F. He was promoted to rank of Major, March 3, 1919, and was discharged May 14, 1919, at Camp Custer, Mich.

While a member of the A. E. F., Major Rafferty participated in the following operations against the enemy; Luneville Sector, February 22, 1918; Baccarat Sector, April 3, 1918; Champagne, July 4, 1918; Champagne-Marne, July 22, 1918; Aisne-Marne, July 30, 1918; St. Mihiel, September 12, 1918; Essey and Pannes Sector, September 16, 1918; Meuse-Argonne, October 10, 1918. He also served in the Army of Occupation.

In the death of Major Rafferty the community loses a public spirited citizen and a physician of marked ability; the service, a loyal and valuable officer.

His intelligence and fineness of character endeared him to all who knew him and the world is the better for his having lived.

DAVID A. KRAKER,

Colonel, Med.-O. R. C., Commanding.

Marriages.

GOLDSTEIN-WESSEL.—Dr. Hyman I. Goldstein, 1909, Medical, University of Pennsylvania, of 1425 Broadway, Camden, N. J., was married to Miss Dorothy Wessel of Camden, N. J., on September 24, 1924.

SPAULDING-DAVENPORT.—On October 4, 1924, Dr. Charles Milton of Buffalo, N. Y., to Miss Helen Althea Davenport, daughter of Dr. Peter B. Davenport of 764 South Orange Avenue, Newark, N. J.

WOOD-ASSMANN.—On October 9, 1924, Dr. Earl Le Roy Wood, 106 Roseville Avenue, Newark, N. J., to Miss Flora Assmann of East Orange, N. J.

Personal Notes

Physicians' Motor Club of Camden, will hold their fall meeting at The Camden Club, on November 18th. Martin O'Hay will be the entertainer. This will be ladies' night for wives and sweethearts, and a banquet will be served.

Dr. J. E. L. Van Sciever and son, Cecil, of Camden, have just returned from a motor trip through Pennsylvania and New York.

Dr. Samuel B. English, of Glen Gardner, visited Camden the past week to see his sister, Mrs. H. L. Rose.

Dr. James Jefferson, of Johnstown, Pa., is traveling with Major Way.

Continued on page XXIV.

On the main line of the Lehigh Valley and the Central Railroad of New Jersey. Three and one-half hours from Philadelphia. Four hours from New York. Eight hours from Buffalo. One hour from Wilkes-Barre.

SUNNYREST SANATORIUM

White Haven, Pa.

A Private Sanatorium for Incipient Cases of Tuberculosis

LOCATED high in the Blue Mountains of Pennsylvania, 1,300 feet above sea level, you have at your very doorstep the best of the delightful scenery of a region noted for its natural beauty and healthful climate.

There are both cottages and individual bungalows. All rooms are private.

For patients on exercise, there is a centrally-located dining-room. Bed patients are served by competent maids. There is an experienced *chef* with a natural appreciation for good and wholesome food.

There are modern facilities for the most advanced methods of treatment. There are specially trained graduate nurses always in attendance.

Patients with a natural appreciation for comfort, service and amusement, will find Sunnyrest a delightful place. For those on exercise, there is a newly finished miniature outdoor golf course with all the thrills and hazards of a full-length course. There are wide

verandas and comfortable chairs. There are charming walks through woods of spruce and pine and oak.

Patients are under the direct medical supervision of the following well-known physicians: Drs. H. R. M. Landis, Joseph Walsh, Frank A. Craig, Isadore Kaufman, Elmer H. Funk, all of Philadelphia, and Dr. Alex. Armstrong of White Haven.

Terms for private room in Cottages: \$30.00, \$32.50, \$35.00 and \$40.00 per week. Terms for individual bungalows with private bath and dressing-room: \$45.00, \$50.00, and \$60.00 per week. This includes everything but Medical Fees.

Reservations are now being made. For particulars, address:

IVAN F. GOODRICH, Gen'l Manager

Sunnyrest Sanatorium (East Side) White Haven, Pa

Orange
Publishing
Company
Printers, Publishers
and Stationers
 14 So. Day Street,
 Orange, N. J.

Mutual
Pharmaceutical Company

INCORPORATED

MANUFACTURING PHARMACEUTISTS

OWNED AND OPERATED
 BY AND FOR PHYSICIANS

*Hundreds of Physicians Testify
 to the Reliability of our Prod-
 ucts and Money Saved on
 Purchases. :- :- :-*

LET US ADD YOUR NAME TO OUR
 MAILING LIST

Syracuse

New York

PERSONAL NOTES.

Continued from page 374.

Dr. and Mrs. Charles E. Teeter of 418 Orange street, Newark, returned recently from Bailey Island, Me. They have a summer home there and have been away since shortly before Labor Day.

Dr. and Mrs. Frederick C. Horsford, who spent a month at Monhegan Island, Me., have returned to their home, 305 Belleville avenue, Newark.

Dr. Harvey M. Ewing of Newark and Montclair has returned from his vacation.

Dr. Ambrose F. Dowd, of 357 Mt. Prospect avenue, Newark, has been appointed by Governor Silzer to succeed Edward L. Katzenbach of this city as a member of the State Board of Control of Institutions and Agencies. Dr. Dowd is resident physician of the Newark City Hospital.

Dr. Henry B. Orton of 704 Parker street, Newark, has returned after a sojourn in Maine, and attending meetings of the American Academy of Ophthalmology and Otolaryngology at Montreal. He was away about a month.

Dr. and Mrs. R. C. Ribbans of 63 Central avenue, Newark, their daughter, Miss Gladys Ribbans, and son, Robert Ribbans, have returned from a trip to Canada. Dr. Ribbans and his family spent the summer at Green Pond.

Dr. and Mrs. R. W. Moister sailed recently for Cuba and will take a short trip through the South, returning in three weeks.

Dr. Mefford Runyon of Grove terrace, South Orange, has leased his home for a year to Mr. and Mrs. Charles D. Henry of 237 Turrell avenue, South Orange.

Dr. and Mrs. Francis E. Knowles, formerly of South Orange, who have a summer home at Cocoanut Grove, Fla., will spend the fall season at the Braidburn Country Club, Madison.

Dr. A. Charles Zehnder and Dr. E. A. Curtis have returned to Newark from a two weeks' tour of New England and Canada. Mrs. Zehnder and Mrs. Curtis were with them.

Dr. and Mrs. Lester R. Davis, of 58 Elizabeth avenue, Newark, will return from Europe in about a month.

Dr. William Brewer, Woodbury, entertained at dinner October 14th the members of the Woodbury Physicians' Club.

Dr. Henry C. Barkhorn of Johnson avenue, Newark, arrived on the S. S. Duilio at New York on October 15th. He left for a vacation in France, Switzerland and Italy in August. Dr. Barkhorn has inspected many of Europe's important hospitals and has conferred with noted French and Italian surgeons and specialists. Mrs. Barkhorn made the trip with him.

Dr. L. G. Beisler of Hillside has broken ground for his new home at North Broad street and Bailey avenue.

Dr. William Cox of Montclair has occupied his new residence on South Fullerton avenue.

Dr. W. H. Lawrence of Summit entertained the Summit Medical Society at its regular meeting on October 24th at the Canoe Brook Country Club.

Continued on page XXV.



IVY HALL SANITARIUM is situated at the entrance of Tumbling Dam Park, Bridgeton, New Jersey.

A quiet homelike private Sanitarium for the care of the invalid, aged neurasthenic and all cases requiring rest, hygienic, scientific and dietetic treatment. Our table and tray service is of the best. Our nurses courteous and kind. We have single rooms, rooms with baths or complete suites. Massage, hydrotherapy, electrotherapy. Telephone 630. Send for booklet.

REBA LLOYD, M. D., Bridgeton, N. J.

Continued from page XXIV.

Dr. Paul E. Menk of 367 Washington Street, Newark, who is to be married November 12 to Miss Loretta Morrison of Reading, Pa., was given a farewell bachelor dinner in the Newark Athletic Club on October 25th by a group of his associates in the profession. He received a set of silver table ware from brother physicians who were associated with him at the Newark City Hospital and at the Newark City Dispensary for a number of years.

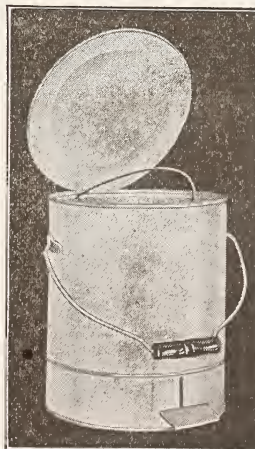
Dr. and Mrs. Carl H. Ill of 505 Clifton Avenue, Newark, returned on October 24th from Bermuda. They have been away two weeks.

The Medical Club, of Philadelphia, held a reception on October 17th in honor of Frank Adelotte, D. Lit., L.L.D., President of Swarthmore College. The Camden Society was represented by the following members: Drs. Howard F. Palm, Albert B. Davis, Thomas E. Hughes, W. H. Pratt, Oram W. Saunders, Edward C. Pechin, Edgar Clements, Grafton E. Day, Horace L. Rose, William A. Westcott, Gordon F. West, Hyman I. Goldstein, Alexander MacAlister and William B. Jennings.

Dr. Clarence W. Way, of Sea Isle City, N. J., a former President of the Cape May County Medical Society, is spending several months vacation in Europe. Much of the time will be spent in visiting the hospitals in London and Paris. Dr. Way was three years in France during the World War, serving most of the time in U. S. Military Hospital No. 1, retiring with the rank of Major.

Continued on page XXXIII.

Betzco Sanitary Waste Pail



Useful double container Waste Pail. Durable, heavy-gauge steel. White enamel. Outer container has tight-fitting steel top, operated by a foot lever. User does not touch pail. Tight-closing lid prevents contaminations and odors.

Ample capacity inner container makes frequent emptying unnecessary. Galvanized. Bail for carrying.

For convenient disposal of all waste materials. Saves time, labor. Helps keep office neat, orderly. Sanitary. Should be in every physician's office.

6CJ1100. Betzco Sanitary Waste Pail
12-quart, each \$3.95
16-quart, each 4.45

FRANK S. BETZ CO., Hammond, Ind.; New York, 6 W. 48th St.; Chicago, 30 E. Randolph St. Use nearest address. Gentlemen:

Enclosed find \$..... for which send me one Betzco Waste Pail, 6CJ1100 quart size. This order under the terms of your unconditional guarantee.

Name

Address

City..... State.....

AN INVITATION TO PHYSICIANS

Physicians in good standing are cordially invited to visit the Battle Creek Sanitarium and Hospital at any time for observation and study, or for rest and treatment.

Special clinics for visiting physicians are conducted in connection with the Hospital, Dispensary and various laboratories.

Physicians in good standing are always welcome as guests, and accommodations for those who desire to make a prolonged stay are furnished at a moderate rate. No charge is made to physicians for regular medical examination or treatment. Special rates for treatment and medical attention are also granted dependent members of the physician's family.

An illustrated booklet telling of the Origin, Purposes and Methods of the institution, a copy of the current "MEDICAL BULLETIN" and announcements of clinics, will be sent free upon request.

THE BATTLE CREEK SANITARIUM

BATTLE CREEK.

Room 111.

MICHIGAN.

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Personal and Dependable Service, Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments

PLACE	NAME AND ADDRESS	TELEPHONE
NEWARK, N. J.....	Smith & Smith, 160 Clinton ave.....	700 Waverly
PLAINFIELD, N. J.....	Runyon & Son, A. M., 402 Park ave.....	40 Plainfield
SOUTH ORANGE, N. J.....	Ardrey, Fred, 106 Prospect st.....	201 South Orange
WESTFIELD, N. J.....	Brown, E. N., 47 Elm st.....	59 Westfield

Armour and Company announce the addition of Parathyroid and Calcium Lactate Tablets. Each tablet contains 1-20 grains of pure Parathyroids and 2½ grains Calcium Lactate U. S. P. These tablets are packed in bottles of 100 and they are obtained from drug trade and dealers in physicians' supplies everywhere.

Logical.—A teacher of music in a public school was trying to impress upon her pupils the meaning of "f" and "ff" in a song that they were about to learn. After explaining the first sign, she said, "Now, children, what do you say; if 'f' means forte, what does 'ff' mean?"

"Eighty!" shouted one enthusiastic pupil.—*Youth's Companion.*

PRESIDENTS, SECRETARIES AND REPORTERS OF COUNTY SOCIETIES.

County	President	Secretary	Reporter
ATLANTIC.....	Clarence L. Andrews, Atl. City...	Edward Uzzell, Atlantic City.....	Royal E. Durham, Atlantic City
BERGEN.....	Herman Trossbach, Bogota.....	C. N. Dexter, Englewood.....	Flora Adams, Hackensack
BURLINGTON..	Harold E. Longsdorf, Mt. Holly.	George T. Tracy, Beverly.....	R. I. Downs, Riverside
CAMDEN.....	Charles H. Jennings, M'ch'tville.	Thomas B. Lee, Camden.....	Horace L. Rose, Camden
CAPE MAY.....	Charles L. Gandy, Ocean View....	Eugene Way, Dennisville.....	Eugene Way, Dennisville
CUMBERLAND..	E. C. Lyon, Bridgeton.....	H. Garrett Miller, Millville.....	Elton S. Corson, Bridgeton
ESSEX.....	Clarence R. O'Crowley, Newark.	Frank W. Pinneo, Newark.....	Alfred Stahl, Newark
GLOUCESTER..	Sam'l F. Ashcraft, Mullica Hill...	Ralph K. Holinshead, Westville	Henry B. Diverty, Woodbury
HUDSON.....	E. J. Luippold, Weehawken.....	Wm. L. Yeaton, Hoboken.....	Wm. Freile, Jersey City
HUNTERDON...	Byron M. Harmon, Frenchtown....	O. H. Sproul, Flemington.....	Morris H. Leaver, Quakertown
MERCER.....	Alvan W. Atkinson, Trenton.....	A. Dunbar Hutchinson, Trenton..	A. Dunbar Hutchinson, Trenton
MIDDLESEX...	Arthur L. Smith, New Brunswick.	Frank C. Johnson, N. Bruns..	Frank C. Johnson, N. Bruns
MONMOUTH...	Harry W. Ingling, Freehold.....	John C. Clayton, Freehold.....	Harvey S. Brown, Freehold
MORRIS.....	Wm. A. McMurtrie, Morristown....	Henry W. Kice, Wharton.....	Marcus A. Curry, Greystone P'k.
OCEAN.....	Ralph R. Jones, Toms River.....	Robert Buerman, Lakewood.....	Geo. W. Lawrence, Lakewood
PASSAIC.....	Thomas A. Dingman, Paterson.....	Louis G. Shapiro, Paterson.....	Louis G. Shapiro, Paterson
SALEM.....	Franklin H. Church, Salem.....	J. F. Smith, Salem.....	William H. James, Pennsville
SOMERSET...	Fred'k A. Wild, Bound Brook....	A. Anderson Lawton, Somerville..	Daniel S. Renner, Skillman
SUSSEX.....	William E. Brown, Franklin....	F. P. Wilbur, Franklin Furnace...	H. D. Van Gaasbeek, Sussex
UNION.....	D. R. McElhinney, Elizabeth....	Irving Lerman, Elizabeth.....	Russell A. Shirrefs, Elizabeth
WARREN.....	Charles H. Lyon, Phillipsburg...	L. C. Osmun, Hackettstown.....	F. A. Shimer, Phillipsburg

The Secretary of the component society should promptly notify the Recording Secretary of the Medical Society of New Jersey of any error or change in these offices.

Try using an advertiser's coupon

Journal of The Medical Society of New Jersey

Published on
the First Day of Every Month



Under the Direction
of the Committee on Publication

Vol. XXI, No. 12 ORANGE, N. J., DECEMBER, 1924

Subscription, \$2.00 per Year
Single Copies, 25 Cents

FOOD COMBINATIONS: AN ORIGINAL SCHEME OF EATING BASED UPON THE NEWER KNOWLEDGE OF NUTRITION AND DIGESTION.*

By **N. Philip Norman, M.D.,**

Instructor in Gastro-enterology, N. Y. Polyclinic Medical School and Hospital.

New York City.

Modern medicine has tabulated a vast amount of information relating to the processes of life. Investigators and clinicians are adding daily to this storehouse of information. There are innumerable facts on record, pertinent to the solution of vital medical problems, which are lost in the files and never applied practically. The ineffectiveness of medicine in coping with many medical problems is not due to a lack of information related to the problem, but to the non-correlation of known positive or negative facts. The reasons for this lack of correlation are diversified; ranging from a callous indifference to medical progress to a lack of time and opportunity on the part of clinicians.

Possibly the most confusing chapter in medicine today is the one related to the problem of diet. Text-books on treatment are woefully barren of tangible information. The authors assume that the medical man is sufficiently schooled in dietaries. Instructions concerning diet are usually dismissed with the admonition, "Of course, the diet must be carefully planned, etc." The greatest reflection on medical intelligence is to be found in the diet kitchens of the hospitals. The interns, the nurses, and

the patients testify voluntarily of the shortcomings of hospital fare. It is traditionally accepted by patient and physician as part of the disagreeableness to be expected in the process of hospitalization. Dieticians are too often nothing more than cooks, who feebly attempt to enhance the physical attractiveness of food without thought or knowledge of the patient's nutritional requirements.

The average meal consumed today is the outgrowth of the efforts of cooks who have catered to taste rather than to reason. The basic plan is to combine proteins, carbohydrates and fats. The conception of the calorie has retarded logical and rational reasoning in regard to diet, more so than any single other factor. The calorie is definitely associated with protein, carbohydrates and fats. The calorific conception is a fuelistic rather than a nutritional conception. Nourishing such a complex aggregation of cells designated as the body differs widely from the problem of burning fuel to make steam.

If life is worth living, it is logical to yield to the desire to prolong it, so long, at least, as satisfaction is derived from it or given by it. And giving way to this desire for the past centuries, people have striven to increase the number of their days, sometimes by rational methods and too often by irrational measures unfounded either in reliable empiricism or in correct theory.

Economics teach the biologist that the prolongation of life beyond the age of effectiveness is a perversion. Man should be a contributor to the dynamics of his community and not a burden. On the other hand, there can be no doubt of the biologic desirability of increasing the health span of the individual and ultimately that of the race. The individual should be protected by organized society against enemies, especially microbic and parasitic organisms,

*Read by invitation before the 158th annual meeting of the Medical Society of New Jersey, at Atlantic City, N. J., June 6th, 1924.

which either produce structural or functional damage or transmit agencies which are inimical to the life span of the individual subject to their beligerancy.

While the fight against parasitic enemies must continue indefinitely, it is no less important to teach people how to strengthen their internal defenses so as to combat the evils of these invisible foes and to impress upon them that bacterial invasion is predicated, in the majority of instances, upon how erroneously they have lived in the past. One's biologic past makes one's biologic present possible or impossible.

The Surgeon-General's records during the past war reveal astonishing facts concerning the health and defects of the nation's youth. Forty-seven per cent. of the total number recruited or drafted had defects worthy of note. This does not include other defects which were not disqualifying.

John D. Comrie in the November, 1919, issue of the London Lancet, gives the following statistical data which is significant. The rejection rate at the age of eighteen was twenty-two per cent.; at the age of twenty-three, it was forty-eight per cent.—an increase of one hundred and eighteen per cent.; at forty, it was sixty-nine per cent.—an increase of two hundred and eighteen per cent. over the age of eighteen. Stated more tersely, at eighteen approximately three out of four are fit for active military service; at twenty-three, only two out of every four; and at forty, one out of every four.

In the British vital statistics, the death rate at twenty to twenty-five years of age was fifty-five per cent. higher than at the age of fifteen to twenty; at the age of thirty-five to forty-five, it was one hundred and forty-five per cent. higher than at fifteen to twenty years of age.

The Surgeon-General's statistics approximately substantiate the death rate in this country as compared with the British death rate.

We are told that the life span of man is lengthening. This is relative. The reason for it is because the pediatricians are preventing the death of numbers of weakling infants by better feeding. Weakling children are protected from the ravages of contagious diseases by the municipal and state health campaigns against the spread of these diseases. Many of these children would have succumbed, twenty-five years ago. However, these children, whose health is below par, whose constitutional integrity is

mortgaged early in life, will, in most instances, have a shorter life span than the average child. Therefore, within a few years it is logical to believe that these inferiors will swell the death rate and shorten the life span in average. The offspring of these weaklings may also increase the death rate. A study of actuary statistics shows that the chronic diseases are on the increase despite improved sanitation, better medical attention and the efforts of preventative medicine. We are all appalled by the increase of the rate of occurrence of cancer. The attention is fixed on cancer because of the tragic course of this disease. We accept, however, such causes of death as apoplexy, heart failure, renal disease, etc., as almost natural causes of death because of their commonness. Yet they are far more active in terminating life than cancer.

The average death rate at a comparatively young age doesn't mean that a biologic law fixes the life span of man from forty-five to fifty years of age. It is direct evidence strongly suggestive that something must be wrong. Moreover, it proves that the health span is short—ten to fifteen years, when a man really feels like working without forcing himself to the task through the coercion of economic necessity.

No one knows how many years should go round before one dies of old age. Death from natural causes has rarely occurred. When it does happen, it is around the century mark. Therefore, it is simply a conjecture as to what really constitutes old age, or in more tangible terms, how many years should elapse before we are old. Time is not an entity. It is an abstraction, a combination or synthesis of space and energy. You cannot touch it and it cannot hurt you. It is not time that causes age, but the things that happen in the course of time to cause us to develop disease, prematurely age, and prematurely die. Since time has been eliminated as a factor of ageing, let us inquire as to the chief reason for ageing.

Since we are all ageing prematurely, developing infections and diseases, it is logical to believe that there is some underlying cause common to all. It is an accepted fact today that most diseases are due to some type of bacterial infection. This is true as far as it goes, but it has its limitations. Bacteria are omnipresent. For a certain time we are comparatively free of infection, yet, none of us escape the ravages of bacterial activity. Therefore, there must be a common cause operating on all of us to make possible this bacterial invasion.

Therefore, bacterial infection is the result of some causal agency and is not a direct cause of diseases. It is the intermediary effect, or an intermediary cause, because the deteriorative and chronic diseases represent the sum total of the terminal manifestations of the primary and intermediary causes. What is the primary cause?

Perhaps the most revolutionary conception in medicine is that serious diseases, functional disorders, and organic inferiority of diverse types, may be caused by a deficiency or excess, or a combination of deficiencies and excesses, of certain food constituents. Experimental work has shown that diseases may be produced by the prolonged feeding of faulty food. Beri-beri, dental caries, rickets, pellagra, scurvy, osteoporosis, mucous colitis, gastro-enteritis, etc., have been produced experimentally by faulty diet.

FAULTY FOOD.

"We no longer eat many of our foods in their natural state. The preparation of food for preservation, storage and transportation alters its food value in many instances. Grains have been robbed of a great part of their mineral and vitamin content when used to make bolted flour, which is closely akin to laundry starch. No one seems to know what happens to fresh milk after it is pasteurized, evaporated or dried. Most of the calcium has been removed and the vitamin content impaired or destroyed. The cartilaginous and tendinous portion of fleshy food are discarded and no one would think of eating blood or the soft portion of bones. The peelings of fruits and tubers are discarded and much of the mineral value is thus lost. This is particularly true of potatoes. We insist on pure white sugar when brown sugar would serve our needs best. Table salt has been deprived of iodine, calcium and other minerals which are essential in nutrition. These are but a few of the examples. Moreover, this injury to food does not end in the processes of preservation and preparation. Vegetables may be lacking in those necessary proximate principles if grown upon soil unsuited for their proper nutrition, or if deprived of sunlight. Milk may be lacking in these principles if the cow is fed upon provender grown upon impoverished soil. The same is true for the meat of animals fed upon faulty provender. Therefore, there are many agencies contributing to the production of faulty food, although the physical characteristics of the food may not appear to be altered."⁽¹⁾

Certain classes of perishable food stuff, owing to the difficulties attending their transportation, compel us to be satisfied to some extent with an improper food balance. Recently, there has been much said about the vitamins, scientifically and commercially, and many now believe that a lack of vitamins is the chief cause of the so-called deficiency diseases and other nutritional disorders.

Investigators have conclusively shown that there are other principles as important as the vitamins and that their absence negatives the value of the vitamins just as much as the absence of the vitamins negatives the food value of the other. Paradoxical as it may sound, it is the very element of the population which could afford a good food balance among which a devitalized diet is observed most frequently. The poorer classes, eating coarser bread and utilizing all the vegetable parings and fats, subsist on a diet much richer in vitamins and minerals.

FAULTY FOOD AND DIGESTIVE TRACT INFECTION.

McClendon has recently contributed a very instructive article on the relation existing between diet and dental caries. In his study of the nutrition of teeth, he has found that they require all the food elements needed by the body and in addition certain chemical elements like calcium, fluorine and the phosphate-ion to give them the proper texture. He has shown that there is a relation existing between diet and the metabolism of bones and teeth and that the metabolism of bone and teeth is similar.

He concludes that the changes in the bones due to deficient diet are of two main types: first, rickets, which is due to a deficiency of phosphate. The growing areas of bone fail to calcify and there is an overgrowth of soft bone matrix or osteoid tissue. In this condition, the teeth develop late and the enamel is thin and soft. The second condition, due to calcium starvation, produces osteoporosis. He does not consider osteoporosis to be totally a specific manifestation of calcium starvation as this condition occurs in scurvy and beri-beri, in which there was no intention of producing calcium starvation. The teeth in this condition usually show an increase in the activity of odontoblast cells with the formation of irregular osteodentin.

He states that it is difficult to determine the deficiency of calcium or phosphate in the diets of humans, but sums up some worthwhile conclusions as follows:

A diet of meat and graham bread contains sufficient phosphate but is deficient in calcium. Milled cereals are deficient both in calcium and phosphate, and he considers that the excessive use of milled cereals, including polished rice, patent flour, corn meal, cream of wheat, and rolled oats, is perhaps responsible for the greater part of the shortage of calcium and phosphate in the average diet. He has shown that rats whose rations included graham flour were normal; while control rats fed the same diet, excepting for the substitution of patent for graham flour, developed rachitic symptoms. Calcium and phosphate occur in cow's milk in sufficient amount for nutrition. To sum up his conclusions, calcium, phosphate and the vitamins A, B, C, D and X seem to be necessary for the proper development and the maintenance of the proper nutrition of bones and teeth.⁽²⁾

McCarrison, whose opportunities for the observation of the effect of diet on man and animals has been very unique, and whose observations have extended over a long period of years, has been able to produce definite endocrine disorders by vitamin deficiency in association with faulty food balance. He has shown the close relationship between a proper diet and a harmonious metabolic state. He has called attention to the necessity of providing food which will maintain and sustain the endocrine balance. The work of the other investigators mentioned has proven that goiter, rickets, scurvy, ophthalmia, beri-beri, pellagra and other diseases are due to a deficiency of some essential principle of nutrition. McCarrison has been able to produce gastro-enteric pathology in man and monkeys by feeding natural foods from which he had extracted one or more of the vitamins or to which he had added an excess of starch or of fats and starch. By feeding this faulty food over variable periods of time he has been able to produce diarrhea, dysentery, dyspepsia and gastric dilation, gastric and duodenal ulcer, intussusception, colitis and failure of colonic function. He does not believe that these conditions are invariably produced by faulty food or that faulty food is the only cause of them. He does contend, however, that faulty food is often at the bottom of their causation and if natural or well-balanced food were used from birth, that their occurrence would be lessened materially. His conclusions regarding the experiments on monkeys manifesting gastro-intestinal conditions in con-

sequence of the various deficient foods employed, are summed up as follows:

(1) "The health of the gastro-intestinal tract is dependent on an adequate provision of vitamins. The absence of growth vitamins is capable of producing pathologic changes in the tract which frequently assume the clinical form of colitis. This observation is of the highest importance in view of the frequency with which this malady is encountered at the present day. Deficiency of vitamin C is especially concerned in the production of congestive and hemorrhagic lesions in the tract, and evidence of these may be found in animals which have not exhibited during life any of the clinical manifestations of scurvy in noteworthy degree. A state of ill health of the gastro-intestinal tract may thus be a prescurbutic manifestation of disease due to insufficiency of this vitamin, especially when associated with an excess of starch or fat or both in the food."

(2) "The disorder of the gastro-intestinal tract consequent on vitamin deficiency is enhanced when the food is ill-balanced."

(3) "Pathologic processes resulting in this situation from deficiency and ill-balanced foods are: (a) Congestive, necrotic and inflammatory changes in the mucous membrane, sometimes involving the entire tract. (b) Degenerative changes in the neuromuscular mechanism of the tract, tending to dilation of the stomach, ballooning of areas of small and large bowel, and probably to intussusception. (c) Degenerative changes in the secretory elements of the tract—of the gastric glands, the pyloric glands, the glands of Brunner, the glands of Lieberkuhn, and the mucous glands of the colon. These changes are such as must cause grave derangement of digestive and assimilative processes. (d) Toxic absorption from the diseased bowel, as evidenced by changes in the mesenteric glands. (e) Impairment of the protective resources of the gastro-intestinal mucosa against infecting agents, due to hemorrhagic infiltration, to atrophy of the lymphoid cells, and to imperfect production of gastro-intestinal juices. This impairment not only results in infections of the mucous membrane itself, but also permits of the passage into the blood stream of micro-organisms from the bowel. (f) It is to be emphasized that the pathologic changes found in the gastro-intestinal tract are more marked in some individuals than in others; and that, while all of them may occur in one and the same subject, it is usual to find considerable varia-

tion on the incidence of particular lesions in different individuals."

"These observations are significant and when coupled with his additional observations that in uncivilized races, gastro-enteric conditions are very infrequent, are convincing proof of the relation of faulty food to enterocolitis. He was led to inquire why certain uncivilized tribes possessed such magnificent physique and preserved for so long the characteristics of youth, were so long-lived and unusually fertile and free from the functional nervous disturbances. During a period of nine years, when his operating list averaged more than 400 major operations a year, he never saw a case of asthenic dyspepsia, of gastric or duodenal ulcer, of mucous colitis or of digestive tract cancer. He attributes the infrequency of these conditions to four circumstances:

1. Infants are reared as nature intended them to be reared, at the breast. If this source of nourishment fails, they die; and at least they are spared the future gastro-intestinal miseries which so often have their origin in the first bottle.

2. The people live on the unsophisticated foods of nature—milk, eggs, grains, fruits and vegetables. I do not suppose that one in every thousand of them has ever seen a tinned salmon or a chocolate or patent or infant food, nor that as much sugar is imported into their country in a year as is used in a moderately sized hotel of this city in a single day.

3. Their religion prohibits alcohol, and although they do not always lead, in this respect, a strictly religious life, nevertheless, they are eminently a teetotal race.

4. Their manner of life requires the vigorous exercise of their bodies.

"The habits of these primitive people in respect to food are in striking contrast to those of our more highly civilized communities. These primitive people are content with natural foods in their natural state, that is, milk, eggs, grains, fruits and leafy vegetables, protective foods as McCollam has named them, "for they provide in proper quality and proportion the proximate principles and vitamins necessary for nutritional harmony and the proper vegetable residue for the healthy evacuation of the bowels." This information, so briefly reviewed, seems to establish experimentally and clinically that digestive diseases are due primarily, perhaps in almost every instance, to faulty food deficient in proximate principles or containing an excess of certain

kinds of proximate principles or a deficiency of vitamins."

"Correlating these facts, it appears that digestive tract pathology is due, in many instances, to a deficiency of minerals and vitamins, especially vitamin C, which is further intensified by an improper balance of food, especially an excess of starches and sugar and fats."⁽³⁾

A study of the infection history of the majority of my cases has suggested that the focal infections, resulting from the prevalent use of faulty food and a poorly balanced diet, are first obviously manifest as focal infections occurring in dental tissues, tonsils, sinuses and respiratory tract.

In studying manifest gall-bladder and intestinal infection, I have been impressed with the history of the number of acute recurring infections involving chiefly the upper digestive and respiratory tracts, or by the presence of chronic focal infection of these tracts, which apparently preceded the infection of the lower intestinal canal. At least focal infection in these structures occurred apparently before there had been any manifest involvement of the intestinal tract; this may be explained by the survival of the productive forms of intestinal bacteria in these instances. The relation of focal infection to the chronic types of diseases is an accepted fact. The relation, however, of faulty diet to focal infection is a fact too little appreciated by the profession and the layman. From the evidence, I have adduced that focal infection of the digestive tract is predicated to an almost absolute extent upon the faultiness of the dietary of a given individual, and, therefore, if we are to scientifically treat chronic diseases, our first effort should be to educate the patient to eating, not as his taste dictates, but as the proper nutrition of his body demands.

To offset the deficiencies of the average diet, the so-called balanced meals have been introduced and for the time being everyone is accepting this dietary with confidence. McCullon and Simonds have prepared an excellent work, "The American Home Diet," into which balanced menus have been introduced, with instructions for their use. These meals are the ordinary meals fortified with green vegetables, fruit and milk. Custom has so shackled the thought of investigators that they have not been able to break away from the bread, meat and potato type of diet. The balanced meal therefore, is simply an improvement as regards the balance of dietary essentials. It

does not take into account the physiologic processes of digestion.

We know that there are six dietary constituents requisite for proper nutrition—1, minerals; 2, vitamins; 3, carbohydrates; 4, fats; 5, proteins; and 6, cellulose.

Any dietary should include all of these factors; however, certain physiologic limitations of the digestive cells should be kept in mind. At this point, I wish to call your attention to some very pertinent findings of Pavlov, who is possibly the greatest living physiologist of the day. These observations are quoted from his book, "The Work of the Digestive Glands." No attempt will be made to detail the nature of the experiments which made possible these conclusions. It is needless to say that the reading of the experimental details would enhance the conclusiveness of the observations which I quote.

He has shown that the first secreted portions of the gastric juice are much stronger in digestive power than the juice secreted an hour or so later. The strongest juice is poured out when it is most needed—when the quantity of food is large and when its structure is coarse. He has proven that each kind of food calls forth a particular activity of the digestive glands and that the powers of the juice vary with the quality of the feeding. Experiments by one of his co-workers, Khizhin, has shown that feeding mixed diets, or separated administrations of milk, bread and meat, calls forth each time special modifications in the activity of the gastric glands. The secretion response is not "limited to the powers of the juices but extends to the rate of its flow, and also to its total quantity." Therefore, the kind of food not alone determines the digestive power of the gastric juice, but also its total acidity. The acidity is greatest with meat and least with bread. "Comparing equivalent weights, flesh requires the most and milk the least amount of gastric juice, but taking equivalents of nitrogen, bread needs the most and flesh the least. The gland work per hour is almost the same with milk and flesh diets, but far less with bread. The last, however, exceeds all the others in the time required for its digestion, and the flow of juice is consequently prolonged."

"Each separate kind of food determines a definite hourly rate of secretion and produces characteristic limitations in the powers of the juices. Thus with a flesh diet, the maximum rate of secretion occurs during the first and second hour, and the quantity of juice in each being approximately the

same. With a bread diet, we have invariably a pronounced maximum in the second hour; and with milk a similar one during the second and third hours."

"On the other hand the most active juice occurs with flesh in the first hour; with bread in the second and third; and with milk in the last hour of secretion. Thus the period of maximum outflow, as well as the whole curve of secretion, is characteristic for each diet."

These facts strongly suggest that the variations observed in gland activity during the course of digestion have some essential meaning. Since each kind of food produces a special curve of secretion, there must be a definite purpose for it, and a special significance to the secretory reaction.

Pavlov holds that the work of the digestive glands, while elastic, is at the same time specific, precise and purposive. "The work of the gastric glands, in providing juice for the different food stuffs, must be recognized to be also purposive in another sense. The vegetable protein of bread requires for its digestion much ferment. This demand is supplied less by an increase in the volume of the juice than by an extraordinary concentration of the fluid poured out. One may infer from this that it is only the ferment of the gastric juice that is here in great requisition, and that large quantities of hydrochloric acid would be useless, or possibly injurious. We see, from the following, that during gastric digestion of bread, an excess of hydrochloric acid is actually avoided. The total quantity of juice secreted on bread is only a little larger than that secreted on milk. It is distributed, however, over a much longer time, so that the mean hourly curve of juice with the bread diet is one and one-half times less than after taking milk or flesh. Consequently, in the digestion of bread but little hydrochloric acid is present in the stomach during the period of secretion. This harmonizes well with the facts of physiologic chemistry, namely, that the digestion of starch is impeded by an excess of acids."

"From clinical observation, we know further that, in cases of hyperacidity, a large part of the starch of bread escapes unused from the gastro-intestinal canal, while the flesh is excellently digested."

From the foregoing quotations, it is obvious that the digestion of carbohydrates and of proteins is quite different. In other words, it is almost incomparable, for the

requirements of each are so different that, when mixed, one forestalls the proper gastric digestion of the other. There is another observation at this point which must be taken into consideration since carbohydrates, proteins and fats are always mixed. Fats have no stimulating effect on the gastric gland. It matters not whether the oil or fat is introduced before a meal, during the meal, or after the meal—the result is the same. If introduced before or during the meal, an inhibitory influence upon the secretion of gastric juice makes its appearance at once. If introduced after the meal and after the juice has begun to flow, it exerts an inhibitory influence which lasts usually for one or two hours.

Fat depresses, that is inhibits, the normal energy of the secretory processes and this inhibitory effect is not wholly mechanical, but for the most part chemical. This is shown by the results of administering cream—that is, milk with an increased amount of fat. If the fat is to be credited at all with the small amount and low digestive power of the milk-juice, that secreted upon cream should be still less and still weaker; and as a matter of fact, this is the case.

The effect of fat on the secretion of gastric juice is not, however, limited to the inhibition of the flow of the gastric juices. Its preventative or inhibitory influence may last from one-half to two hours, but a secretion of gastric juice begins again in the third hour if the meal of fat be at all large. This late secretion lasts a long time and furnishes a considerable quantity of juice and is an explanation for many cases of hyperacidity produced by the partaking of oils, butter fats, and meat fats with a protein meal. With these facts in mind, we restrict patients from combining or from adding to the protein meal such supplementary articles of diet as butter, oils, whipped cream, ice cream and milk.

The partaking of butter fat and oils with the starchy meal does not hinder the digestion of the starch so much, because, as we will recall, the maximum digestion of starch occurs between the second and third hours. With these facts at hand, we are in a position to plan a dietary which will adjust itself to the physiologic limitation of the digestive cells.

It is well at this point to present some pertinent facts concerning the proteins:

PROTEIN AMINO-ACIDS

"Abderhalden estimates that the number of possible combinations of twenty known

amino-acids, in which each individual amino-acid is present once and only once, is represented by a number composed of thirteen digits. With this possibility, it is easy to comprehend how different classes of proteins present differences in internal structure, even though by ordinary methods they are regarded as identical. Proteins of different animals may present less evident differences. Such differences have in recent times been demonstrated biologically in proteins heretofore regarded as identical; that is to say, the very proteins which perform identical functions in different animals are not themselves identical, but differ from genus to genus, from species to species; and the more widely separated from each in the evolutionary scheme, the greater the differences of such proteins. The effect of this conception upon physiologic thought has been and must continue to be far-reaching." (Fitch, *Dietotherapy*, Vol. I, p. 67).

"Abderhalden's study of cytolysins affords evidence that the proteins of the liver, spleen, pancreas, and possibly other organs, have very special peculiarities. Each kind of food stuff, and indeed each individual protein fraction, follows its own special metabolic path. Moreover, there are paths for fats and paths for carbohydrates, and it is evident that even dextrose and levulose are dealt with in different manners; for a patient, whose power of burning dextrose is grossly impaired, might deal with the levulose with far better success. In the same way the power of catabolizing a single protein fraction might be lacking in an individual who has been able to dispose of other protein fractions in a normal manner. It is believed that these changes are wrought by special enzymes, many, if not all, of which are capable of reverse action." (Fitch, *Dietotherapy*, Vol I, p. 73).

In studying the action of different enzymes, one is struck by Emil Fischer's statement that there must be a special key to each lock. The ferment being the lock and its substrate the key, and if the key does not fit exactly to the lock, no reaction is possible. In view of this fact is it not logical to believe the admixture of different types of carbohydrates and fats and proteins in the same meal to be distinctly injurious to the digestive cells, if, since it is true that similar, but not identical, locks are produced by the same types of cells, it is logical to believe that this admixture taxes the physiologic function of these cells to their limit.

Hutchinson believes that it is very much

better to eat several small meals than one large meal, and goes on to point out that one large meal a day is disadvantageous because it is apt to overburden the mechanical powers of the stomach to the extent that some of the constituents of the food are partially wasted; and that the assimilative powers of the tissues are being overworked, to keep pace with the flood of nutriment which reaches them, at the same time; and he calls attention to the fact that the chief danger of the large meal is the overtaxing of the digestive powers of the stomach, and it is a well recognized clinical observation that persons of feeble digestive powers are benefited when the quantity of food is limited, and the golden rule for these people is to eat little and often.

Keeping Emil Fischer's statement in mind, we attempt to prevent the formation of an extensive number of key and lock combinations by limiting the number of different proteins in a meal; for instance, we do not recommend a meal made up of oysters, fish, beef meat, plus such proteins as may be contained in a leguminous vegetable, or in ice cream or cake, which makes a total of five different distinct proteins to be metabolized. We attempt to limit the proteins to two types.

A point worthy of note in regard to the separate administration of concentrated starches is one concerning the pancreatic secretion of the proteolytic enzyme. The action of trypsinogen is of the greatest moment. It has been finally demonstrated that pancreatic juice, as secreted, is free from proteolytic effects. Therefore pancreatic juice as secreted is normally carbohydrateolytic and lipolytic. However, it becomes proteolytic when a change occurs in the juice itself, that is, when trypsinogen is converted into trypsin. This is brought about by the action of enterokinase after the juice enters the gut. When this occurs, the pancreatic juice acquires a proteolytic power superior to that of any other digestive juice, so that the proteins of the food undergo a very thorough disintegration. Trypsin acts more rapidly than pepsin and more powerfully upon certain proteins which are difficult of digestion in the gastric juice. Acting on solid proteins, such as fibrin, it eats from the surface to the interior. Trypsin goes further than pepsin and rapidly splits up the proteose and peptones which have left the stomach into similar substances—the polypeptids—

and the polypeptids are readily dissolved into other constituents, amino-acids.

Since this is true, is it not logical to believe that mixing concentrated proteins and starches at a meal, either forestalls the digestion of the other, or weakens the digestion of both by the pancreatic juice, and is it not better to allow the pancreatic juice to have a free hand at carbohydrates or at proteins, rather than at both. And, since we know that the quantity and properties of the digestive secretions vary with the character of the food, it is reasonable to assume that the less complex the substrate, the more easily it will be to find the lock and key combination.

Up to the present we have slighted a discussion of the enzymic action of the saliva and it is pertinent at this point to call attention to a factor or so relating to it.

The function of the saliva in the process of digestion is to hydrolize starch and in this way prevent the absorption of pepsin by the colloidal carbohydrate—serving thus as a material aid to digestion. Therefore peptic digestion is delayed in the presence of colloidal starch solution through absorption of salivary enzymes. This supports Pavlov's work, in which he finds that digestion of starch in the stomach is most active between the second and third hours.

Between the amyloextrin and erythro-dextrin stage in the digestion of the starch molecule, the absorption of pepsin is lost. Unboiled starch does not hinder the action of pepsin; this is a significant fact in connection with the dietetics of herbivora. Further, cooked farinaceous foods, as rice, potato, bread and porridge, inhibit peptic digestion if not first subjected to salivary digestion. It seems clear, therefore, that the ptyalin in human saliva plays a considerable part in aiding gastric digestion by hydrolizing colloidal starch, which otherwise would absorb pepsin. This is logical because it would seem an odd physiologic prank that an enzyme should be secreted in the mouth only to be presently destroyed in the stomach." (Fitch, *Dietotherapy*, Vol. 1, p. 124).

HISTORICAL SUMMARY.

It is impossible in this brief communication to correlate all essential information to prove the doctrine of food combination which I shall present to you presently; but before going on to other considerations, it is well to present at this point a summary of some conclusions that have been reached by studying the evolution of diet from the stand-point of the procuring of food, the

development of argiculture and the development of the art of cookery, as well as gazing into the light that the science of anthropology has shed upon man and his food.

Fitch, in his work "Dietotherapy," Vol. 1, has arrived at the following conclusion regarding the evolution of the diet of man. He believes that there are three events of dietary importance which materially influenced evolution—first, the discovery of cookery; second, the advent of the agricultural era; and third, the domestication of animals. These innovations permanently influenced the character of the diet of man, and have changed the manner of his life in many respects. He states, "While civilization, based upon the results of cookery and cultivation, has been a blessing to mankind, it has not been an unmixed blessing regarded from the standpoint of health. In early times, the food of our ancestors was such that much of it required vigorous mastication, with the consequence that little starch was taken into the stomach in the crude form. At the present time, the reverse is the case; a very large amount of practically pure starch is ingested, and owing to its soft-consistency and the consequent lack of mastication and insalivation, slips down into the stomach in a state totally unprepared for digestion, giving rise to various disorders and to malnutrition. This condition is particularly true in the case of infants. *The supply of sugar is also increased and it is eaten to an inordinate extent. This, taken in connection with the augmented consumption of vegetable food, gives rise to the conclusion that the present generation is likely to suffer from the undue consumption of both starch and sugar.* No dogmatic statement can be made as to the relative values of animal and vegetable food as articles of diet. Since men have lived in good health as vegetarians or nearly vegetarians, and also solely on meat, these examples do not prove the point."

"Climate has a great influence on the nature of a diet; occupation is a factor that must be considered, and heredity is not a wholly negligible quantity. In a general way, it may be said that animal food appeases hunger more thoroughly than a vegetable diet and satisfies it for a longer time. It gives more stay to the stomach and it has a more stimulating effect upon the system generally."

"In spite of the fact that man is descended from the ape, and that the ape is more frugivorous by far than carnivorous, the fact remains that the small size of man's

stomach, due possibly to his erect posture, demands a concentrated diet, and this diet would seem to be best supplied by meat. Cookery affects the relative values of animal and vegetable foods in opposite ways, with regard to mastication. Cooking coagulates the albumin of animal tissues, hardening it so that mastication may be necessary; cooking of vegetables does away with the need for mastication. It cannot even be argued that either animal or vegetable food is a natural diet of man, for while his ape ancestors did not eat much flesh, at one time of his early career as a human, man was more carnivorous than frugivorous. The present conformation of his jaws and teeth, the result of an evolutionary process, does not single him out as especially adapted for a vegetable or an animal diet. Whatever primitive man may have been considered from the dietetic standpoint, he is now a mixed feeder in temperate climates. Descending from ancestors whose diet for long ages has varied in a temperate zone, man would naturally find a varied diet best suited to his needs and to his taste. His anatomic history also shows that his digestive system is wholly adaptable to these variations, and is capable of being modified to almost any extent."

"His adaptability affords an explanation of why he has fallen into the routine of the existing civilized mode of diet. Eating food of soft consistency, which is a universal habit, has had and is having an injurious effect upon his jaws and teeth, upon his salivary glands and upon his digestive system. He should revert to some extent to the food of his simian ancestors—raw vegetables and fruit, which would afford plenty of exercise to his masticatory, salivary, and digestive organs. A simple diet is in the main the ideal one. If he continues to eat soft, cooked foods—and it does not seem very likely that he will not—then in the course of time, it may be expected that a type of person will be evolved capable of dealing with the quantity and kind of food which our revised civilization has decreed that we shall consume."

"Perhaps it is possible that we have come to the end of our progress in the direction of diet, and that the human race will be the better for going back to the simple diet of our ancestors. It must be borne in mind that extreme luxury in diet has been noted more than once in the history of the world—that of the Persians and Romans, for example. Afterward a period of compara-

tive simplicity has ensued, until a climax has been reached."

"The acme of dietary excellence was achieved not long after the age of agriculture, cooking, and domestication of animals came in. Since then, the increase of population, industrialism, and other concomitants of advanced civilization, have made further dietary changes necessary. At the present time, the situation must be met in the best ways possible."

"The chief object of this chapter has been to point out and lay stress upon the fact that man's evolution has been greatly dependent upon the evolution of his diet and it is to be hoped that this object has been fairly well attained." (Fitch, Dietotherapy, Vol. 1, pp. 49-50).

It is well to take into account the researches of Blatherwick, who has shown the importance of the acid producing and alkali producing foods. These may roughly be divided as follows: ^(4, 5)

The neutral foods are the oils, fats and creams; the acid producing foods are the concentrated proteins and the concentrated starches; and the alkali producing foods are the fruits, vegetables and milk. The only exceptions among the fruits are prunes, plums, and cranberries, which, while containing base forming elements, are, however, finally excreted as hippuric acid, and this acid is an irritant to renal tissues. Rhubarb is also excluded because of its oxalic acid content.

We know the value of the maintenance of the alkali reserve, and the maintenance of this alkali reserve is directly predicated upon the amount of alkali contained in the diet. If the dietary is made up of a combination of foods which are acid producing and into which a minimum of the alkali producing foods are combined, there will result an excessive formation of acids in the intestinal tract and in the tissues themselves. To counteract the effect of these preformed acids, the blood is called upon to supply the necessary bases for their neutralization, and if the diet is deficient in these basal elements, certain organic structures, especially bones, teeth and blood are demineralized. Therefore, it is well to separate the acid forming foods in such a fashion that we may be able to combine enough alkali forming foods to offset the acids produced during digestion, or cellular metabolism of these acid forming foods.

It is possible to plan three meals a day made up of foods containing the six nutritional essentials without combining at each

meal the concentrated proteins, carbohydrates, and fats. This is accomplished in the following manner:

The first meal, or breakfast, is made up of fruit, preferably raw, and milk. This is the remineralization and revitaminizing meal. Raw fruits, and to a lesser degree, cooked fruits, contain food salts necessary for the maintenance of the nutrition of bones and teeth, and supply the blood stream with alkaline salts to counteract a condition popularized under the name acidosis. The vitamins are contained in abundance in raw fruits. This is especially true of vitamin C. The fibrous structure of the fruit, cellulose, supplies bulk and retains moisture—two factors which promote bowel activity. The natural sugars of the fruit supply the body with the heat and energy requirements and in general promote the growth of protective types of intestinal bacteria.

Milk contains water, minerals, vitamins, fats, sugar and proteins. The combination of milk and fruits will not produce acidity unless eaten in combination with foods containing starch and sugar.

Meat, or a meat substitute, is not included in the breakfast menus as the physiologic requirements are taken care of at the evening meal.

The breakfast of preference is the citrous fruits and milk, which may be alternated with any other fruit or berries to fit seasonal changes and break the monotony of the fare. The milk may be heated but not boiled. In this meal, all the essentials of nutrition are included without the admixture of the concentrated proteins and carbohydrates to forestall proper digestion and to form excessive amounts of fermentative acids.

The mid-day meal: It is the heat and energy producing meal. It may be served either at noon or the evening. For the average adult, it is best to have this meal at noon because it calls for less digestive activity than the protein meal. It consists of concentrated starches, cooked non-starchy vegetables, a leafy vegetable, and milk if desired. Whole wheat, graham and bran breads are always used instead of the breads made from bolted flour. In this meal, we have a concentrated starch which contains necessary minerals and vitamins; cooked non-starchy vegetables which contain minerals and vitamins and cellulose; a leafy vegetable which contains an abundance of vitamins and minerals and cellulose; milk which contains five of the nutritional essentials. The patient is not carbohydrate-

starved for at all meals he partakes of carbohydrates, and at this meal may eat as much of concentrated starch as he wishes. In this meal is incorporated the requisite amount of butter fat because the inhibitory effect of the fat does not hinder the carbohydrate digestion as it does protein digestion.

The evening meal—is the protein meal, or the repair and building meal. We prefer it to be served in the evening. It consists of a concentrated protein; one or two cooked non-starchy vegetables; a raw vegetable; and raw or cooked fruits for dessert. The patient is told to substitute the vegetables or fruits or salads for bread while chewing meat, and there are but few of them who object to the suggestion. Soups are not included in most of the dinner menus. For those manifestly undernourished or underweight, the addition of soup is desirable.

A cup of coffee is allowed with the dinner meal, without sugar. The use of alcoholics is condemned. Carbohydrates are not excluded in the dinner meal because the dessert is made up of fruit, which includes the sweet fruits such as dates, figs, raisins, and grapes.

No water is allowed with the meals. The vegetables, milk and fruit supply the necessary amount of water. At bedtime, milk and fruit may be partaken of if the patient suffers from hunger before retiring.

There are some modifications to this scheme. If it is to be applied to a working man, we substitute a cereal and milk breakfast, and insist on the fruit and milk meal before bedtime. This will supply an adequate amount of nutrition. Therefore into each meal is incorporated all six of the nutritional essentials; yet, at the same time so combined as to have a preponderance of the main constituents occurring at separate meals. This relieves the gastric glands of an unnecessary amount of physical taxation and gives to the system the necessary amount of rest it requires.

One of the chief complaints of people living by this scheme is that they become hungry an hour or so before meals. There is a supposition quite prevalent among the laity, and also shared by some members of the profession, that hunger is an abnormal thing and is weakening. I attempt to educate my patients that hunger is a good thing for them, and I shall attempt to give you my reasons for this.

A paper published by W. N. Boldyreff entitled "The Periodic Activity of the Organism, and Abderhalden's Reaction,"

has brought out some very interesting facts worthy of note. It is concerned with the discovery of a very unique function of the digestive system which he named "The Periodic Activity of the Digestive System Outside of Digestion." In investigating the Abderhalden reaction, which, as you know, is founded upon the theoretic assumption that whenever albuminoid bodies make their parenteral appearance in the body, that is, when they enter it in some way other than through the digestive system, and it does not matter whether it be a direct introduction into the blood of some kind of protein or through the formation of some tumor in any of the organs, or through pregnancy, traumatism, etc., there invariably appears in the blood through some unknown source a special proteolytic ferment capable of splitting up the special kind of protein, and this kind only, which has just been introduced into the body.

He performed a series of tests upon men and animals, of any sex, and age, and both in health and diseased, pregnant and non-pregnant, and conclusively proved Abderhalden's assumption to be erroneous. He found that when the stomach and small intestine are empty, the gastric glands are absolutely quiescent and an alkaline reaction is found in the stomach; but periodically and with clock-work precision there occurs a secretion of juice from the pancreas and from the intestinal glands in the entire small intestine, and also an excretion of bile, all of which are accompanied by strong rhythmic contractions of the stomach and of the small intestine. These periods of simultaneous activity of the organs mentioned last, in dogs, approximately twenty to thirty minutes; in men, somewhat longer. They are followed by periods of complete conjoint rest, lasting in dogs about an hour; in men, somewhat less. During each period of work, between 50 and 60 c.c. are secreted and this fluid contains in ample quantities all the ferments produced in the digestive apparatus, that is, proteolytic, lipolytic, and amylolytic ferments.

His experiments on dogs showed that this fluid is completely absorbed in the small intestine and never reaches the colon. He has further shown that during the period of work these ferments, protease, lipase, and fibrin ferment, make their way into the blood, in which they can easily be detected; whereas during the periods of rest, the first two ferments disappear from the blood and the quantity of fibrin ferment decreases. Thus, when the stomach is empty, the pro-

teolytic ferments appear for a short time in considerable quantities in the blood and then disappear from it—this process being carried on periodically and with great regularity.

The phenomenon of this periodic influx into the blood, alternating with its disappearance from the blood, determines the positive or negative result of Abderhalden's reaction. We are, of course, not concerned with the Abderhalden reaction, but we are concerned with this phenomenon because invariably and periodically, into the blood of all men and animals, are absorbed from the intestine tract ferments which are capable of splitting up fats and proteins.

This investigator concludes that in many pathologic conditions, and also in pregnancy, the periodic activity is more marked, because the period of work during which the ferments enter the blood are not only longer but appear oftener, and, in general, the quantity of these ferments is increased. In other words, in pathologic states, the blood is supplied with proteolytic ferments oftener, during a longer time, and more abundantly than in health. These ferments remain in the blood of diseased individuals for a longer time than in that of healthy ones.

The periodic activity is, so to speak, antagonistic to gastric digestion. The more time in twenty-four hours devoted to digestion, the less is available for this activity; but, if for any reason, digestion in the stomach is absent or shortened, the periodic activity is immediately substituted. Therefore this activity is increased as a result of diminished digestion in the stomach, or if the baneful effects of overeating are obviated.

So it is another point in favor of this diet scheme when I tell you that the average patient cannot overeat, and that two of his meals a day are readily and quickly digested, and that this phenomenon of the periodic activity of the digestive system outside of digestion is more active and more of the proteolytic, lypolytic and fibrin ferments are absorbed to combat diseases. It is evident that these ferments should have a great importance in the phenomena of immunization. Simultaneously with the appearance of these ferments in the blood, there occurs an increase of leukocytosis, and it is needless to tell you the value of this biologic phenomenon.

After studying the problem of diet for six years and after having had numerous forms printed and after correlating all of

the impracticableness contained in these diet lists from the patient's point of view and from the physician's point of view, this scheme of eating which I have outlined to you evolved.

At this point, I wish to acknowledge my indebtedness to Dr. George Huston Bell of New York City, a most original thinker, who has for many years insisted upon the separation of starches and meats at the same meal. I was curiously interested in the reason for this departure from accepted customs and I have found, as I have related to you, logical reasons from physiologic facts which I have just recited to you.

We are told that the meat, bread and potato type of diet is wrong. It has been proven that this type of diet is inadequate for proper maintenance, growth and reproduction, but we have been so engrossed with the details of the arduous experiments which have established this fact that we have lost sight of the physiology of digestion, and, while it is true that we must take into account the kind and quantity of foods ingested, it is even more important to take into account the digestive cells and their secretions, which fragmentize the food molecules into chemical complexes which facilitate absorption.

We must take into account how to offset the acid forming foods, and since the starches and the meats are the acid forming foods, it is so logical to believe that their acid products are more easily neutralized by the offsetting foods when they are partaken of separately and singly.

This scheme of eating is particularly suited to the city dweller, who has not the time, the opportunity, the inclination, and too often, the means for taking exercise. It is one thing to advise a man to take exercise and another thing for him to perform this exercise. We must treat the patient as we find him, not as he should be, and the best way to control that patient's basal metabolism is through his diet. Unfortunately, the average diet scheme is filled with so many complex tables that it requires too much time on the part of the physician to compute the patient's nutritional requirements, and it is too confusing to the average patient to even attempt to figure out. The patient doesn't care to sit at the table and speculate how many grains of calcium he is getting with one glass of milk, or how many grains of protein he is getting with the minute steak. It doesn't interest him whether he gets seventy grams of proteins a day or two hundred grams of protein a day. We may

establish so-called standards which are, after all, only averages, but it is a fallacy to expect every patient to adjust himself to these standards with the same results. This diet scheme automatically limits the patient's food intake. There are very few patients who can overeat on this scheme. On the other hand, if obese, he may, without difficulty, limit the concentrated carbohydrate intake to a nicety without giving it thought. It takes him away from the meat, bread and potato type of diet. It forces him to eat of the food substances containing vitamins A, B, C, D, and X—of the minerals, water, starches, fats, proteins and cellulose. Of course there are some cases in which special idiosyncrasies to certain types of food must be taken into account. Yet in its practical application I have found, that if the patient intelligently applied the dietary principles outlined to him, the assumed idiosyncrasy disappeared. This scheme has been an unquestionable aid to me, not alone to correct the ordinary complaints summed up under the head of indigestion, but also for the purpose of restoring the metabolic balance of patients suffering from serious chronic diseases. It is a scheme that I believe should be applied to every prospective mother. It is a scheme that should be taught to every child. For if we are seriously attempting to strengthen the race, we must begin with the mother before the child is born and then educate the child to take care of itself, and by so doing, the grandchildren of the present generation will be materially better off than their grandparents of today.

This diet is practical—it is especially adapted to the man who lives in restaurants. His breakfast he can procure for himself without the need of going to a restaurant. His luncheon he may procure in any restaurant, and his dinner he may select from any table d'hôte menu.

I have given to you what I believe to be the most practical application of dietetics that has been advanced to date and I trust that I have said enough to interest you sufficiently so that you yourself may learn this scheme, place your patients upon it, and make careful observations and report them at future meetings of your society.

DISCUSSION.

Dr. Martin J. Synnott, Montclair, N. J.—Dr. Norman has done a great service in calling attention so forcibly to the importance of diet in preserving and restoring health. I believe his ideas are eminently sound. Almost all patients who come to us for the relief of chronic ailments will need dietary regulation. Many of them have been badly advised

This statement applies particularly to patients who because of a trace of albumin or the presence of hyaline casts or indican in the urine, or because of a slight increase in blood urea, have been placed by former medical advisers on a low protein diet. I see many such cases who are really suffering from proteid starvation, and when they are allowed a generous proteid diet, according to Dr. Norman's plan, they improve at once.

It is most important to instruct our patients to avoid foods and combinations of food which produce fermentation in the small intestines and putrefaction in the colon, with the formation of large quantities of toxic acids and poisons which have to be neutralized and eliminated. The protective organism of the body almost always breaks down eventually under the strain of such long continued overwork where incorrect food combinations are persistently used. Intestinal poisoning and the toxic colons are, I believe, the underlying cause of many chronic conditions, and responsible for many of the involutional diseases such as arteriosclerosis, angina pectoris, myocarditis, nephritis, neuroses, senility and insanity, which form the syndrome of "old age."

That the colon is often overlooked as a causative factor in disease is graphically shown by the following case report. The patient, male, 35 years of age, was referred to me for relief of a chronic multiple infectious arthritis involving both knees, ankles and wrists. He was bed-ridden. The blood Wassermann was negative. Urine showed a low grade secondary nephritis. He was greatly emaciated. Foci of infection were discovered in his teeth, tonsils and right antrum. These were cleared up in turn; first the diseased teeth were extracted, then after an interval of six weeks the tonsils were removed, and after another interval of two months a radical antrum operation was performed. No improvement whatever was noted after these various operations and we then decided to study his gastro-intestinal tract by the Lyon method. The gastric digestion was normal, there was no duodenitis, no bile-duct or gall-bladder infection. An x-ray study, however, showed a 72 hour colon stasis and a fecal examination revealed a highly toxic, foul smelling, putrid stool with a marked disturbance in flora. He was at once put on Dr. Norman's treatment,—colon irrigations, acidophilus milk by rectum and mouth, a regulated diet, etc. In addition we ordered him to take weekly doses of castor oil. The results were most striking and the improvement almost immediate. He has gained 40 pounds in body weight, looks and feels well, walks with a cane, and expects soon to resume his former work as carpenter.

REFERENCES:

- 1 and 3. Norman, N. Philip: *Int. Clinics*, Vol. I, Series 33, 1923. J. B. Lippincott & Company, Philadelphia.
2. McClendon: *J. A. M. A.*, Vol. 79, No. 14, Sept. 30th, 1922.
4. Blatherwick, N. R.: *Arch. Int. Med.* 14: 409, Sept., 1924.
5. Idem: *J. A. M. A.*, Vol. 81, No. 11, Sept. 15, 1923.

PREOPERATIVE, OPERATIVE AND POST-OPERATIVE CARE OF PATIENTS SUFFERING FROM PROSTATIC HYPERTROPHY.*

By **Oswald Swinney Lowsley, A.B., M.D., F.A.C.S.,**

From the Department of Urology, James Buchanan Brady Foundation.

The greatest advance ever made in prostatic surgery is the realization by most urologic and general surgeons that there must be a preliminary period of drainage before actual removal of the prostate.

Next in importance has been the advance in our knowledge of anesthesia. Gas and oxygen, and ethylene taking the place of chloroform, which is a liver poison and results in the patient's death from 8 to 10 days after operation, and ether which is very irritating to the kidney. The latest development in successful anesthesia is induction of regional anesthesia by means of novocain and similar drugs giving an entirely satisfactory anesthesia for prostatectomy by our method and marking a real milestone in the advance of prostatic surgery. Last and of least importance is the choice of operative route. Our experience has given far superior results with a modification of Young's perineal approach, and that method is utilized unless there is some specific reason for using the suprapubic route.

When a prostatic presents himself, he should be given a careful general and special examination, including rectal palpation, an estimation of the amount of residual urine, and a cystoscopic examination to determine the exact nature of the enlargement. The removal of an enlarged prostate when there is very little or no residual urine is specifically contra-indicated except in special instances. The size of the prostate as felt per rectum has nothing whatever to do with its obstructiveness. Therefore, cystoscopy is essential to indicate the extent of the intravesical and intra-urethral intrusion.

The preoperative preparation of the prostatic consists chiefly of drainage. This should be intermittent in character when the patient is first seen. In complete retention it is well for the bladder to be emptied by catheter, irrigated and partly refilled with boric acid solution and the process repeated

intermittently as indicated. A complete emptying of the retentive bladder may so disturb the patient's pressure balance as to institute an uremia. If intermittent catheterization is well borne, it should be continued for a short period and later should become continuous either by means of a retention catheter or, better, by means of a suprapubic cystostomy under local anesthesia.

It would seem that the latter procedure were much to be preferred because it is on the whole less disturbing to the average patient. Intermittent catheterization is almost sure to be accompanied by traumatism and an exacerbation of the cystitis which almost always is present by the time the urologist sees the patient. Experience teaches us that the indwelling catheter is not well borne by the prostatic, although there are certain exceptions to this general rule. It frequently is accompanied by acute cystitis, acute epididymitis and acute or subacute urethritis. Catheter drainage is so annoying to the average patient that its benefits are offset partially and in some cases entirely by the discomfort which it produces.

The double tube and suction drainage, which has been in use at the New York Hospital for many years seems to be the ideal type of drainage. The patient is placed in a chair for varying lengths of time after the fourth or fifth day and is kept dry and clean and has perfect drainage without any of the annoyance which accompanies suprapubic syphon drainage or drainage by retention or intermittent catheterization.

We have come to believe that old men thrive when they are comfortable and properly cared for as regards food, bathing and other nursing, and, like babies, if they are wet, improperly fed, unbathed and uncared for, they will fade away and die. There is probably no other class of patients which responds so rapidly and unfavorably to neglect as the old prostatic, except very young babies.

LENGTH OF TIME OF THE DRAINAGE PERIOD

One of the most important things about the period of drainage is to have no set time for it. The drainage period is only over when the patient has reached his maximum of renal efficiency. This is determined by a comparison of the following tests taken before the preliminary operation and at frequent intervals thereafter:

(a) Urea in a 24-hour specimen to determine the amount excreted.

*Read at the 158th Annual Meeting of the New Jersey State Society on June 7, 1924.

(b) Blood chemical tests to determine the amount of urea, nonprotein nitrogen and creatinin retention and also the acidity of the blood.

(c) Last of all, a color test to determine the activity of the renal epithelium at that particular time. Two drugs, phenolsulphonaphthalein and indigocarmin are most helpful in this regard, in the order named.

There are many other tests of renal function, each of which has its adherents. Among these are: The Mosenthal concentration test, cryoscopy, estimation of the output of various substances like potassium iodid, sodium chlorid, etc.

In addition, and probably more important than any single test, we find that the patient must be considered as a human being and, regardless of the excellence of his kidney tests, if his *general condition* is not as nearly perfect as it can be made, his operation is postponed until he feels perfectly fit and anxious to proceed.

Diet.—Fluids are forced and the patient is given a soft, meat and alcohol-free diet during his preoperative course. There is no objection to his eating fish, poultry and sweets in moderation unless there is some specific contra-indication.

Medication.—It is well to put the patient on urinary antiseptics until 24 or 48 hours before operation. Hexamethylenamin in ten or fifteen grain doses taken an hour after the administration of an acidifying agent such as acid sodium phosphate or sodium benzoate is a suitable one if borne well by the patient.

A day or two before the operation the patient is put on sodium bicarbonate administered by mouth or as 5% solution per rectum. It is well to purge the patient the day before operation so that the night preceding it he may have an entirely undisturbed period of rest and slumber. His lower bowel is emptied by enema a few hours before going to the operating room. On the day set for operation he is given a final thorough physical examination which includes the general appearance, head (eyes and tongue particularly), chest abdomen, extremities and a careful review of his temperature chart, pulse rate, and blood pressure comparisons.

Several instances of the final round-up of tests and examinations being responsible for the saving of a patient's life can probably be recalled by every urologic surgeon. I shall briefly mention two such cases. The first, is one which I operated upon when I had the honor of serving in Doctor Keyes

Department in Bellevue Hospital shortly before I entered the Navy.

A mulatto T. S., age 60, had been drained by the usual suprapubic cystostomy for over two weeks and seemed to be in excellent general condition. Routine phenolsulphonaphthalein tests were done on the day before that set for the operation. The return, which had increased in a gratifying manner, now showed a very low percentage, verified by a repetition of the tests. The patient stated that he felt well, and there was no evidence of *intércurrent disease*. We, however, postponed the operation, and very fortunately, because when his temperature, was taken at 4 P. M. that afternoon, it was considerably elevated and the next day he had a full blown case of pleurisy. He was ultimately operated upon successfully after a three or four weeks' delay.

Another case of mine at the New York Hospital, Mr. John G., showed 24 hours before the time set for his perineal prostatectomy, that he was in a condition bordering on acidosis, as demonstrated by the routine blood chemical examination. His operation was postponed for several days as the condition was readily relieved by administering large doses of sodium bicarbonate. The phenolsulphonaphthalein test had shown an increased improvement throughout.

Summarizing the preoperative preparation of the prospective prostatectomy patient one feels that he should be drained, until he has absolutely reached the peak of his efficiency not only from the standpoint of renal function, but from every angle, including his own personal feelings and appearance. He should be fed, bathed and groomed in every sense of the word by specially trained persons, more carefully and painstakingly than any world's champion was ever trained, and the operation itself should be postponed until all conditions are as near correct as possible.

The old practice of removing the prostate as soon as the diagnosis is made is happily disappearing, and the knowledge that a preliminary period of drainage is necessary has permeated almost the entire medical profession.

METHOD OF ADMINISTRATION OF SACRAL ANESTHESIA.

The following is the routine procedure which we have developed, and **attempts to** deviate from it have caused unsatisfactory results in one way or another:

The patient is prepared for operation in the usual manner as regards purgation,

enema, etc. One hour before going to the operating room an opium suppository (gr. 1) is inserted into the rectum. Just as he starts for the operating room he is given a hypodermic of Magendie's Solution. Recently we have been giving the patient $\frac{1}{8}$ of a grain of morphin in 2 c.c. of 50% sterile mag. sulphate in accordance with the method of Gwathmey. Upon arrival he is placed upon his elbows and knees or upon his abdomen on the table. The skin is then infiltrated at the point where the needle is to be inserted, the skin first having been sterilized in the usual manner. The operator then palpates the coccyx, and sliding his finger above this bone reaches the lower part of the sacrum and is usually able to palpate the sacral hiatus without difficulty. The sacral horns adorn the lateral borders of a triangle of which the hiatus is the apex. A four-inch needle is inserted through the anesthetized skin and into the sacral canal by puncturing the ligament which covers its lower end. After penetrating this ligament, the needle is easily pushed in one and a half to two inches. It has to be guided carefully otherwise it will impinge on bone and must, of course, be deflected. One learns to tell by the ease with which the needle passes and the direction it takes whether it is in the canal. One of the directions the needle may take is just over and to one side of the roof of the canal. This error is detected by the direction of the needle and the fact that it passes with difficulty. One can also check up on this position, if improperly inserted, by the fact that as soon as the injection is started the tissue at the end of the needle will infiltrate with the solution.

The needle having been inserted into the canal, one observes its end carefully to see whether either blood or spinal fluid runs out. In the event of this complication the needle is withdrawn to a point where blood or fluid ceases to appear and then makes the injection. If the solution runs in easily one is sure that he is in the canal. If, however, the injection is made with difficulty one is quite sure that the needle is not in the canal and the tissues over the sacrum are observed for infiltration.

We have been using 35 c.c. of freshly prepared 2% novocain solution injected into the canal without the addition of bicarbonate solution. We have not used adrenalin in the injected solution because we believe that it adds greatly to the toxicity of the drug.

We have long been under the impres-

sion, from clinical observation, that adrenalin added to local anesthetic adds greatly to its toxicity without adding any material benefit whatever. Those who advocated its use believe that it is not rapidly absorbed. This opinion is differed with strongly by D. Murray Lyon of the University of Edinburgh (Jour. of Experimental Medicine, Dec. 1st, 1923, Vol XXXIII, No. 6, page 655), who states: "The impression seems to be widely prevalent that adrenalin, given subcutaneously, causes little general effect and its action is quite uncertain. This view is probably based on the blanching of the skin which is seen around the site of injection, and on the fact that adrenalin causes vasoconstriction of some vessels. But the spectacular relief from distressing symptoms that occurs in asthmatics within a few minutes after a hypodermic injection of a minute dose of adrenalin has been given, is in itself evidence that absorption by this route is rapid and satisfactory. It is suggested that absorption can take place freely by lymphatic channels."

Emil Mayer (Jour. of the American Medical Assn., March 15th, 1924, Vol. 82, page 876), states: "And it seems probable that adrenalin was a contributing factor in many of the deaths recorded." The statement that "animals bear larger doses of procain when small doses of epinephrin are injected simultaneously into the veins" is not based on animal experimentation, at least no experiments are quoted.

Leo Schmidt (Gottinger Thesis, 1919), states that the fatal action of subcutaneous and intravenous administration of adrenalin in guinea pigs has a very uniform foundation. The cause of death is always to be found in lung hemorrhages perhaps with the additional action of a lung edema, which leads to death by suffocation without striking individual variation in susceptibility from a definite, sufficiently sharply defined border dose.

Braun (Local Anesthesia, 1924, page 67), states: "Like all narcotic substances they (local anesthetics) are all protoplasmic poisons, paralyzing not only the nerve elements but the function of all protoplasm with which they come in active contact. This action they possess in common with many other active substances, even with the physical action of water upon protoplasm. Their intense selective affinity for nerve substances is particularly characteristic. They paralyze the function of nerve tissues with which they come in active contact in solutions too weak to appreciably influence

other kinds of protoplasm. The affinity of these substances for nervous tissue makes them particularly toxic to the central nervous system."

Thus, we see that both the local anesthetics and epinephrin have a special affinity for the nervous system. When injected intravenously into experimental animals in toxic doses they produce nervous symptoms, excitement, convulsions, central paralysis and finally death by respiratory or cardiac paralysis. Epinephrin is 450 times more toxic than procain for experimental animals.

Meeker & Frazer (*Jour. of Pharmacology & Experimental Therapeutics*, Vol. 22, No. 5, Dec., 1923), "In certain regions absorption is more rapid than in others, for example, in the sacral canal and on each side of the vertebral column, a fact which accounts for a great likelihood of toxic manifestations in paravertebral and sacral anesthesia. . . . Injections should be made cautiously if strong solutions are used about the head, pharynx and sacral canal. . . . No doubt the incidence of reactions to local anesthetics would be greatly reduced were it possible to dispense entirely with adrenalin. We would even take issue with Braun's contention that local anesthetics should be compatible with adrenalin and maintain that the drug replacing procain for local anesthesia should be either more powerfully anesthetic in proportion to toxicity or less toxic in proportion to anesthetic power, making adrenalin unnecessary."

The injection into the canal is extradural and presumably elevates the dura from the bone under the pressure used. In this procedure one may safely use a quantity up to 60 cubic centimeters provided the solution is not toxic. We then inject 1 per cent. solution of novocain into the first, second and third sacral foramina on each side in accordance with the method of Labat. The foramina are located rather easily by passing the needle into the depression just below the transverse processes. From 3 to 5 cubic centimeters of 1 per cent. novocain solution is injected into each foramen, the needle being withdrawn in order to distribute it in the entire length of the foramen.

The patient is then placed on his back and 30 minutes by the clock is allowed to elapse before the operation is begun. By that time that part of the patient which sits on a saddle, including the scrotum, urethra and bladder, should be thoroughly anesthetized, if the injection is successful.

We have found that by starting to operate too soon the patient often feels pain and such an apprehensive state of mind will be produced that every movement will cause complaint. On the other hand, if one waits until a thorough anesthesia occurs the patient will go through the operation without protest.

We prefer to remove the prostate by the perineal route for the following reasons:

(1) The enlarged gland can be removed by sacral and parasacral anesthesia without infiltration of novocain directly into the operative field.

(2) All bleeding vessels are clamped and ligated easily under direct vision.

(3) There is not nearly the amount of shock suffered by the patient during the enucleation of the gland because the operator does not subject him to the same amount of pressure and traumatism that is necessary in the suprapubic enucleation. In the latter procedure the operator often gets the whole or part of the hand into the patient's bladder, resulting in considerable pressure being applied to the pelvic viscera and directly or indirectly upon the pelvic plexus.

(4) The patient can sit up in a chair on the third or fourth day after operation without any danger. This gives him a great psychologic boost and results in an important improvement in his morale.

The operation which we do is a modification of Young's perineal prostatectomy. The curved tractor of Crowell is inserted through the urethra into the bladder. The prostate is exposed by dissection through the perineum in the usual manner. The hypertrophied gland is then removed through an inverted "v" incision, the apex of which is deepened into the urethra just as it joins the apex of the prostate. In making this incision care must be taken to cut entirely through the lamella of tissue which separates the posterior from the remaining lobes of the gland, viz., the middle, two lateral and anterior. This incision preserves the ejaculatory ducts, which are intimately adherent to the above mentioned tissue layer, as we have shown in a previous communication. After removal of the gland the tractor is removed and a large, many-eyed catheter is inserted into the bladder. The cavity from which the glandular tissue was removed is then packed lightly with gauze. It is not our method to sew the tongue-shaped piece of the posterior portion of the prostatic capsule back in position as pressure of the surrounding viscera pushes it

into place. The pelvic floor is repaired by placing one catgut stitch through the levator ani on each side, whence it had been pushed, and pulling the two portions together. The skin is then repaired in the usual manner with silk worm gut.

POSTOPERATIVE CARE OF THE PROSTATECTOMY CASE.

This care is interpreted to begin immediately after the actual removal of the gland. The wise surgeon puts a stop to the hemorrhage before beginning to sew the wound. This is easily accomplished in the perineal prostatectomy because bleeding points can be and are observed, clamped and ligated in a satisfactory surgical manner. The general ooze which always occurs is controlled by packing the cavity of the prostatic capsule lightly with gauze strips. If one packs any cavity too tightly the viscus exerts its well known quality of attempting to expel the foreign body and the spasmodic contractions resulting tend to cause continued hemorrhage. Suprapubically, a very different problem presents itself. The cavity of the former site of the enlarged prostate is in a most inaccessible spot. It is possible in case of severe hemorrhage to put the patient in Trendelenburg position and expose the area, clamp and tie off bleeding vessels and this should always be done when the hemorrhage is not controlled by light gauze packing.

The use of such appliances as inflated rubber bags to control hemorrhage, or very tight packing of any sort, seems to be particularly contra-indicated because of the resulting pain, tenesmus and continued hemorrhage due to the attempt which the viscus makes to expel such a foreign body.

Any steps that are to be taken to prevent hemorrhage should be instituted at the time of the operation and the hope that further packing or other manipulations might be accomplished in case the patient continues to bleed for several hours after operation usually results in disaster because any manipulation causes pain and very little pain administered at a time when the patient is in a state of depressed blood pressure will have a profound effect and often throws the patient into shock.

It is important to keep the patient dry and warm and for him to be transported to his bed with as little delay as possible.

Blood pressure estimation is the most important single item in the observation of the patient for the first 24 hours. This should be taken every two hours or oftener until it has passed entirely through its pe-

riod of depression and has arisen to a safe level again.

The two most gratifying features of the removal of the prostate under sacral and parasacral anesthesia have been the facts that the hemorrhage is very much less than it is under any inhalation anesthesia and the subsequent drop in blood pressure is not nearly so great. In only six cases have the postoperative blood pressures been less than 100 mm.; out of 117 major operations performed by this method in the past 14 months.

It is well to avoid postoperative pain by any means possible. With inhalation anesthesia, the patient recovers consciousness in from ten minutes to two or three hours after completion of the operation. He then begins to suffer pain which is more severe if he is too tightly packed, and this has frequently been the cause of bringing on shock because it occurs at just the time when the reaction period is at its lowest ebb as shown by the blood pressure level.

The particularly great advantage of regional anesthesia is that its effect continues from six to ten hours to a certain extent and tides the patient over this trying period of depression, so that he frequently does not have pain at all and usually sleeps well the night after operation.

SHOCK.

Shock is induced by loss of blood, with subsequent pain, and injury to the nervous mechanism. Certain toxic substances are also frequently a factor. Since the adoption of regional anesthesia in our operations upon the kidneys and prostate, shock has almost entirely disappeared from our wards. There has been one case only in the past year and that was not fatal.

The ordinary methods of combating shock are familiar to every one; raising the foot of the bed, keeping the patient warm, administering fluid and stimulants by mouth and rectum. Salt solution as administered intravenously raises the blood pressure for a brief time and in slight cases this is often enough to tide them over. We prefer, however, the use of gum-glucose solution as prepared by the New York Hospital Laboratory and described by us in 1921. This method is a slight modification of that successfully used by Ward and Farrar at the Women's Hospital.

The packing is removed in 24 hours or less under ordinary circumstances. The drainage tube in perineal cases is now inserted per urethra and left in until the wounds are healed. Suprapubically, the

drainage tubes are gradually reduced in size and finally removed altogether, drainage then being instituted by means of a tube in the urethra until the suprapubic wound is healed.

The patient is allowed to sit up on the third day for one-half hour, but first a careful examination is made of the legs and thighs to determine the possible presence of thrombus. We feel that if this examination were general, many a case could be saved from fatal embolism. The patient is kept lying quietly in a semi-reclining position for several days longer and not allowed to strain at stool. That act seems to dislodge more fatal emboli than any other activity of the patient.

Just as the internist considers a three months' complete vacation after leaving the hospital a part of the treatment of a typhoid fever case, so should the urologic surgeon insist on a six months' complete vacation for the patient upon whom he has performed a prostatectomy.

SUMMARY OF RESULTS.

Perineal prostatectomies under sacral and parasacral anesthesia (procain).

No. of cases	Youngest	Oldest	Average	Adenoma of Prost.	Carci. Prost.	Op. Post. Shock	Blood under 100	Blood over 100
75	49	86	64½	71	4	3	5	70
	Average stay in Hosp. 42.5 days			Cured 71		Died 4		

Ten of these cases smelled either a little ether or aromatic spirits of ammonia at some time during the operation. None of them received more than a few drops placed on a piece of gauze by the patient himself.

The series of prostates is by far the most interesting and have been studied minutely. These cases number 75. They vary in age from 49 years to 86, the average being 64.5 years. The symptoms of onset began 15 years ago in one case, the shortest period of urinary difficulty being one month. There is no accurate method of determining the average, but it seems to be considerably over a year.

The longest period of stay in the hospital for both suprapubic drainage and prostatectomy was 80 days, the next 78 days, the third longest was 64 days, the average stay of all cases was 42.5 days and the shortest 18 days.

Complete retention occurred in 74% and partial in 26%. The largest amount of urine obtained by catheter was 64 ounces and the least 6 ounces. Sixty-two per cent

of the patients were leading a catheter life; 38% had sought no previous relief. The largest period of catheter life was 5 years, the average was 124 days.

Twenty-four per cent. of these patients were in good general condition, 34% fair and 42% poor. The highest systolic pressure noted was 210 mm. Hg., the lowest 102 mm. Hg. and the average 144.5 mm. Hg. Two per cent of the cases had clear normal urine, 98% had pathologic urine. The highest return in two hours from the intramuscular injection of phenolsulphonephthalein was 85%; lowest 0. and the patient in condition to be operated upon with lowest return of phthalein in 2 hours showed 27% and the average 49%. Eighty-eight per cent of the patients were drained superapubically, the longest period being 9½ months, the next 61 days, the shortest 7 days and the average 22 days; 8% had intermittent catheterization and 4% retained catheter.

The highest blood urea retention on admission as shown by blood chemical examination was 78 mg. per 100 c.c., the average 22.4 and the lowest 10; 17 being considered within normal limits—at the time of operation the average was 15.74, the highest 25.3 and lowest 9.6.

The time of operation on one case was 90 minutes. This was a particularly difficult carcinoma of the prostate in which it was necessary to clamp and ligate a great many bleeding vessels. The average time for all operations was 22 minutes, and the operating was done in 18 minutes on several occasions.

The hemorrhage encountered at operation is surprisingly slight when compared to that noted during operation by any method under any type of inhalation anesthesia. This is due to the fact that in the latter blood pressure is always elevated and hence the increased hemorrhage. The lack of hemorrhage is one of the greatest influences in the prevention of shock; another is the lack of pain which these patients have after operation on account of the fact that the anesthesia persists for 6 to 8 hours after injection and therefore the element of pain is eliminated while the patient is in his post-operative period of slump in blood pressure and general resistance which lasts for five or six hours after operation. In our experience under regional anesthesia, 74% of the cases have had very slight hemorrhage, 16% slight, 8% marked and 2% profuse. One case bled for five days and was finally transfused, one had hypodermat-

clysis, but nothing was required for the others. The packing was removed in 92% of the cases in 18 hours after operation; none were repacked. In 8% of the patients the packing was left in for 32 hours. The perineal tube was usually removed in three days. Most of the patients sat up on the fourth day, occasionally one was not allowed out of bed for a longer period.

Partial control of urination was attained in the average patient in 9 days, the longest time being 21 days and shortest 3 days. Complete control occurred in an average of 17 days, the longest period being 27 days and the shortest 8 days.

The suprapubic wound was closed in every case by the 20th day, the shortest one being 36 hours and the average 9 days. The perineal wounds under our latest method of draining per urethra instead of through the perineum have almost all healed per primum. By the older method 12 days was the average, the longest being 29 days in the case of an infected wound.

POSTOPERATIVE COMPLICATIONS.

The postoperative complications have been very few indeed. The depression of blood pressure and pre-shock conditions which we previously saw frequently have almost entirely disappeared from our wards. We have had only one case of severe shock. Only 3 other cases have had systolic blood pressure below 100 mm. Hg. following operation and only one of these had to have subcutaneous saline.

DEATHS.

There have been four deaths following prostatectomies, as follows:

M. W., age 63—Prepared in usual way, tube out on third day and sat up on the fourth and every day thereafter—on morning of 18th day, while straining at stool, had a sudden collapse and died immediately, apparently from an embolus.

S. W., age 70 years—Died of hemorrhage and shock 18 hours after operation.

R. H. W., age 56 years—Tube removed on third day, upon fourth developed a cellulitis of the sacrum and died on the 13th day after operation.

Wm. S., age 63 years—One-stage perineal prostatectomy. Had an unusual amount of hemorrhage so that he was opened suprapubically on sixth day after operation. Was transfused on 14th day after operation. He improved for a few days and finally developed a septicemia and died on 20th postoperative day. He had an untreated syphilis of 10 years' duration

and had given the disease to his wife and his daughter.

CONCLUSIONS.

As our experience grows, the opinion becomes stronger that the next great advance along surgical lines as applied to urology will be the improvement in noninhalation anesthetic agencies and in methods of administering them.

Adrenalin has been proved by clinical experience and animal experimentation to add definitely to the toxicity of the drug used and should be excluded from all regional anesthetics.

The prostatectomy case has less bleeding and is free from pain for 6 to 8 hours after operation. This fact, coupled with the patients ability to take fluids up to, during and immediately after operation, takes most of the element of danger from this severe operation.

A MATERNAL WELFARE PROGRAM.

By Theodor Teimer, M.D.,

Newark, N. J.

(Abstract from a paper read at a joint meeting of the Maternal Welfare Commission of Essex County and the Academy of Medicine of Northern New Jersey, May 21st, 1924.)

The movement to organize the medical profession in the interest of Maternal Welfare originated in this state in the Essex County Medical Society, in the fall of 1922, when the Public Health Committee of the county society adopted the suggestion of its chairman to concentrate its efforts on this work. Accordingly, on March 26th, 1923, a conference of members interested in this problem was called, and a resolution was adopted, recommending to the Essex County Medical Society the organization of a Commission for Maternal Welfare in Essex County. This resolution was adopted at the May meeting of the County Society, in the year 1923.

It may not be amiss to repeat the essentials of this resolution, because it contains such a concise statement of the objects and scope of the work, that it may be used as a model for the inauguration of similar movements elsewhere.

RESOLUTION.

Proposed by the Public Health Committee of the Essex County Medical Society:

Whereas, The lack of an organization devoted to maternal welfare, embracing the entire county of Essex, has caused all efforts along these lines to be fragmentary, overlapping, disorganized, and not uniform in character and scope, and,

Whereas, The lack of such organized effort has been one of several factors responsible for greater maternal mortality than may be inevitable, and,

Whereas, The people everywhere are entitled to look for guidance and help in such matters to their medical advisors, who in this county are represented by the Essex County Medical Society, be it therefore resolved that,

The Essex County Medical Society, mindful of its duty to protect public as well as individual health, and determined to live up to the great traditions of unselfish service to the communities in which its members practice the healing art, does hereby approve and direct the organization of a body which shall be devoted to maternal welfare in this county, and in which the Essex County Medical Society shall be officially represented by delegates appointed by its president, who may collaborate with other men or women active or interested in public health work.

And the Essex County Medical Society further directs:

That this body shall be known as the Medical Commission for Maternal Welfare in Essex County.

And it further directs that this commission constitute itself as a separate entity, work out its own constitution and by-laws, and obtain its own charter, so that it may be unhampered in its activities by any official ties to the Essex County Medical Society, save by the fact that its members shall sit as delegates of the Essex County Medical Society,

And it further directs that this commission should not have the power to make any decisions legally binding on the Essex County Medical Society or any other component part of the commission, but that the commission exert power by virtue of the wisdom of its recommendations and decisions,

And the Essex County Medical Society specifically directs that this Commission for Maternal Welfare be speedily organized, so that it may proceed to co-ordinate the efforts of the various public and private agencies engaged in the reduction of maternal mortality, that it establish standards for prenatal, delivery and post-partum care, that it keep the public informed by periodically published statistics collected under its auspices, that it concentrate its efforts to increase the efficiency of health departments, hospitals, sanatoria, clinics, physicians, nurses, midwives and other agencies engaged in maternal welfare, that it co-operate with the health departments of the component parts of the County of Essex, and finally that it aid in any other way the cause of maternal welfare.

A subsequent motion was passed at the same meeting, directing the president, to appoint delegates for a term of 1, 2, and 3 years, so that two-thirds of the membership of the Commission are carried over each year.

It would lead too far to explain in detail the reasons for what this resolution contains and what it omits. But some of the salient points may be mentioned:

1.—The fragmentary, overlapping, disorganized and otherwise unsatisfactory character of the maternal welfare work in Essex County is emphasized.

2.—The medical profession is reminded, that the public has the right to expect guidance in such matters from their medical advisors.

3.—That the medical profession recognizes this duty and imposes the execution of it on its own official representatives.

This assumption of leadership is logical because it comes from the only body of medical men that can, without pretense, assert authority in such matters in the county, and because the execution of a maternal welfare program depends primarily on the co-operation of the medical profession, whether as individuals, or as organized in hospitals, clinics, etc.

Any investigation, any recommendation by the Commission, any imposition of new duties will be received as self-imposed, and will not be objected to as outside interference. It insures that the task will be entrusted to safe and sane minds, who will combine experience with other qualifications, that will safeguard the medical men as well as the public health.

4. It assures continuity of effort and lays the foundation for an extension of the work throughout the State.

5. It keeps the door open for affiliation with representatives of lay bodies.

6. In its final paragraph it stresses co-ordination, standardization, education, increased efficiency and co-operation with health departments

Let me now continue to give you the short history of the Commission since its personnel was named by Dr. Augustus J. Mitchell and Dr. Mefford Runyon in 1923.

The Commission organized by electing its officers, adopting a constitution and by-laws, and creating a number of committees, thereby dividing its work into the essential sub-divisions. The Commission has served faithfully and all the meetings were well attended. The principal difficulty, as we can see in reviewing the work of the past months, was to size up the scope of the task, to exclude what is out of our province, to limit ourselves to the practical, to get the viewpoint of the practitioners, the health

authorities, the hospital authorities and the lay organizations, to study the statistical data, familiarize ourselves with laws, and all this with the object constantly in view, to reduce maternal mortality and morbidity. We have done concrete work, such as a survey of all the hospitals in Essex County, with a view to determine all the data bearing on our problem. We have made definite plans, partly made out in detail for education of the public in prenatal care and for clinics to be held at the various hospitals by the respective obstetricians. We have gone to the root of the problem by discussing the cause of death in individual cases and comparing the data available in vital statistics with histories given by attending physicians.

Much valuable material was obtained in this way, but the time was obviously too short to draw any conclusions and adopt any recommendation for action.

The active co-operation of the medical profession in the development of this program is earnestly sought. The Commission will not be found wanting. It is determined to do its duty to the public as well as to the profession. Its personnel was selected by Dr. August J. Mitchell during his term of presidency of the Essex County Medical Society and vacancies were filled by Dr. Mefford Runyon, his successor. The State agency for Maternal Welfare and the Newark Health Department are represented in its membership. The medical profession as a whole and the obstetrical branch are duly represented.

THE ADDRESS OF THE PRESIDENT Mefford Runyon, M.D.,

Delivered at the 109th Annual Meeting of the
Essex County Medical Society, at New-
ark, N. J., October 7th, 1924.

EXPERT TESTIMONY.

You have honored me this past year by electing me to the highest office at your command. I highly prize that honor and I thank you profoundly for your trust. Words are perfunctory and convey in a small way only what I feel. Please read, if you can, between the lines, my heartfelt appreciation.

It is the province of your President upon this occasion to read an address. He would

gladly spare you this additional burden upon your patience, but I promise you he will at least show mercy by presenting *briefly* for your consideration, a subject already a bit threadbare, but requiring some readjustment and some new methods before it can become an honor to our profession. I refer to the medical expert in his legal capacity.

Many years ago the following story was current: Somewhere in Pennsylvania a Dutch judge had been elected to office. His knowledge of law and of court procedure was limited but his common sense was sound. Soon after taking office a case for damages was brought to his court. The case was tried by jury. The man prosecuting had been injured in a railroad accident and was suing for damages. He had two or three medical experts who testified that he had been permanently injured and would never again be the same man. This was embellished with full details. The railroad company offered, in defense, the testimony of other experts who had examined the case. They testified that they could find nothing the matter with him—that, in fact, he was in some respects, better than before the accident, inasmuch as a broken leg received at the time had been set straight and that he was in consequence, no longer bow-legged. The evidence was finally all in, and the judge got up to charge the jury. "Shentlemen," said he, "like me, you haf listened to effidence about dis man. You haf heardt vat hees Doctors say about his case—if you belief vat day say, you must gif him de tamage. You haf also heardt vat de railroad doctors say, dot he is better den he vas before,—if so, den he should get down on his knees and tank dem for de accident. But if, like me, you don't belief a tam vordt dot any of dem say—I don't know what in hell you vill do."

Since this story was first told the status of the medical expert has remained the same. In most instances, he is looked upon with distrust by judge and jury, and with a more or less cynical humor by the public, and, too often, as one false to his code by the profession. He is regarded as a man paid for his testimony in advocating a cause rather than as a high minded and unbiased judge administering the truth according to the evidence as he understands it, regardless of any other consideration.

The expert, in the dictionary sense, is "one being strictly skilled or having special knowledge." In what position does the law place the man in our profession, possessing

such skill and such knowledge? As used in law, "an expert is a person selected by a court or adduced by a party to a cause, to give his opinion on some point in issue, with which he is peculiarly conversant." But the prevailing practice in England and America, is for each side to call its own expert evidence, thus giving full liberty to the witness so called. In France, whenever the court considers that a report by experts is necessary, it is ordered by a judgment clearly setting forth the objects of the "expertise." Three experts are then to be appointed unless the parties agree upon one only. The experts are required to take an oath, but in practice, this requirement is frequently dispensed with. They may be challenged on the same grounds as witnesses. The necessary documentary and other evidence is laid before them, and they make a single report to the court, even if they express different opinions; in that case the grounds only of the different opinions are to be stated, and not the personal opinion of each of the experts. If the court is not satisfied with the report, new experts may be appointed; the judges are not bound to adopt the opinion of the experts. A similar system is to be found in force in many other European countries, notably in Holland, Belgium, Italy and in those colonies where French law has been followed. In Mauritius the articles of the French law, summarized above, are still nominally in force; but in practice, each side calls its own expert evidence, as in England.

There is a considerable body of law in England as to expert evidence. Only a few points can be touched upon here. An expert is permitted to refresh his memory in regard to any fact by referring to anything written by himself or under his direction at the time when the fact occurred or at a time when it was fresh in his memory: This is also law generally in the United States. In Scotland, medical and other scientific reports are lodged in process before the trial, and the witness reads them as part of his evidence and is liable to be examined or cross-examined on their contents. In strictness, an expert will not be allowed, in cases of alleged insanity, to say that a litigating or incriminated party is insane or the reverse, and so to usurp the prerogative of the court or jury. But he may be asked whether certain facts or symptoms, assuming them to be proved, are or are not indicative of insanity. But in practice this rule is relaxed both in England and in Scotland, and (where it exists) to a still greater

extent in America. The weight of authority both in England and in America supports the view that an expert is not bound to give evidence as to matters of opinion unless upon an undertaking by the party calling him for which he should receive a reasonable remuneration for his evidence.

An editorial comment on the presence or absence of insanity in a recent trial is as follows: "It is well agreed that the presence or absence of insanity is a fact for expert determination. Justice would not be done in all instances if the jury were not guided by medical opinion. The great abuse of the law in this regard is the full sweep permitted to expert testimony bought for the express purposes of the defense or the prosecution. The question of sanity should be decided by impartial experts not subject to the inducement of financial reward. The delegates to the psychiatric convention would establish in each state a permanent alienist board to be consulted in legal proceedings involving the issue of insanity, its decision to be final. Dr. Carlos F. MacDonald advocates a commission appointed by the court for this purpose. The essential reform is to do away with the pitched battle before the jury, which defeats justice as often as it serves it. The present practice of expert testimony has few, if any, defenders among the leaders of the legal or medical profession. Is it not time for the bench and bar of this state, in consultation with alienists of high repute, to plan a revision of criminal procedure relating to insanity for submission to the Legislature?"

These laws have been made with the object of obtaining the highest knowledge to enlighten the court in order that strict justice shall be done and with the expectation that fair remuneration shall be bestowed upon those from whom this information comes. It has taken no note of the possibility that such knowledge might be bought by the highest bidder in advocating a cause or in perverting the truth. In England, and much more in America, the expert has been given a free hand in the full belief that highly educated and strictly trained men will speak the truth with no thought of monetary consideration. To what extent has the medical expert respected that trust? The question needs no answer from me. You have only to review the notable cases which have excited great public interest and where the defendants have occupied high social position or great wealth, or both, and where medical testimony has ap-

peared as a determining factor in the final judgment, to receive an unequivocal answer. We have only to read the testimony in such cases, to realize how far men of great ability and high attainments are willing to go to screen the truth. That these men are paid and paid enormously for such work has not only not been a secret, but has at times, amounted to a boast. For such testimony, money may be paid openly, for men so gifted may veil the truth so adroitly that technically they do not break their oath as a witness. A judge so openly paid for his favor would be punished. A medical expert just as definitely adjudicating the evidence, is allowed to go free and unpunished. Medicine is not an exact science. No man is a final authority, hence, in such testimony the skillful fencer can always find a screen around which he may dodge.

There are many men in the profession to whom money or position could never prove a lure to turn them from the truth, or make them hide their real opinion behind a mass of professional technicalities, for such men no law is needed. They are forever staunch and forever reliable. But there are other men, men of ability, men who are daily doing fine work, men of honor in the profession, who cannot stand against the great temptation when it assails them. For such men, the law should lend the strength of its hand to ward off the temptation by adopting some new measure. This plan may be that suggested, as already quoted, by Dr. Carlos F. MacDonald, or a modification of it. But, *and this is my point*, the responsibility rests with the medical profession. The law in this matter has given us full liberty, why do its administrators and most of our thinkers in the profession, feel that the law should be changed and our liberties restricted? If you believe with me, it is because we, as medical men, have been content to let the law deal with the matter rather than take the trouble, and burden ourselves with the work, of establishing a code in our organized bodies which would hold men to a strict accounting for such testimony, or make such testimony impossible. We cannot very well establish the denomination of the fee for such work—nor should that be our wish—but we should get into the field at once and make the first move by organized effort among ourselves to minimize this evil of advocated evidence. It should be our business to see to it that testimony cannot be bought from the medical profes-

sion. We should promulgate the idea that one sufficiently learned to be an expert must not be an advocate—that the very nature of his position makes it impossible for him to become a party to a cause. Once establish this as a custom and the fee for evidence will adjust itself. We may find at times little that is Utopian in modern law courts, but at least we may play our part honorably in making them more so. We have lost greatly the respect of the public. Let us get it back, not by having it thrust upon us by some law which we may be compelled to accept, a law which may not only restrict our present liberties, but take them away from us altogether.

It has been a fine thing, this trust which has been placed upon us. We all like it, but we will surely lose it unless we can give the public and the body of law-makers a certain ground for belief that this trust will no longer be misplaced. We must make them feel that they may rest with confidence upon the action taken in this or that case—sure that, so far as the Doctors are concerned, the medical facts will be administered with probity. A man's credentials are looked into carefully before he can practice medicine. We have taken a firm stand to see to it that the laws governing public health shall be proper laws. We no longer sit supinely by and allow our great profession to be belittled by charlatans and quacks. The abortionist can no longer hold up his head in our societies. We have rooted out many evils.

Let us root out this one and do it ourselves, in order that our medical expert with the high dignity which belongs to him, may show fearlessly the "wisdom of the wise and the prudence of the Elders."

The Three-Minute Gun.

Along the Irish Coast are a number of lighthouses which fire a signal gun at three-minute intervals during foggy weather. To a visitor the noise is irritating and unbearable, making sleep an utter impossibility. So adaptable is man, however, that to the seasoned lighthouse keeper not only does the monotonous boom pass quite unnoticed, but a break in its regularity reacts as a disturbance.

The tale is told of one old Irishman of long service who slept soundly and peacefully during a stormy night while his faithful wife fired the roaring three-minute signals—that is, he rested comfortably until by some shortcoming one of the charges failed to explode. Instantly he awoke, sat up, gazing wildly, and shouted, "Maggie! What in h—was that?"

—Life.

THE JOURNAL

OF THE

Medical Society of New Jersey

Office of Publication:

14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second class matter.

PUBLICATION COMMITTEE:

CHAS. D. BENNETT, M. D., Chm., 750 Broad Street, Newark.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S.
Vermont Apartments, Atlantic City, N. J.

ASSOCIATE EDITORS:

CHRISTOPHER C. BELING, M.D., Newark
HENRY B. COSTILL, M.D., Trenton
JAMES HUNTER, JR., M.D., Westville
HARRISON S. MARTLAND, M.D., Newark
FRED J. QUIGLEY, M.D., Town of Union

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if,—

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to THE EDITOR, Atlantic City, N. J.

The County Society Secretary shall send promptly to Dr. Morrison, Secretary of the State Society, notice of the election of every new member, with his address; also of any changes of members' addresses; also the names of officers elected at the annual meeting.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent direct to THE CHAIRMAN OF THE PUBLICATION COMMITTEE, Newark.

THE EDITOR has now definitely located his headquarters and therefore all literary matter, including manuscript, exchanges, etc., should be sent directly to

DR. HENRY O. REIK

Vermont Apartments, Atlantic City, N. J.

COUNTY SOCIETIES.

It has been the privilege of the Editor to visit during October and November more than half of the County Societies comprised in the State organization, and it is a pleasure to report that a very satisfactory state of affairs exists throughout these components of the State Society. In only one instance was the attendance less than 70% of the total registered membership; a very creditable showing, indeed. Furthermore, the interest displayed in both the business and scientific portions of the programs was very keen. In so far as a visitor might judge, there is the heartiest good feeling among the members all over the state, and not the slightest evidence of any bickerings

or personal disagreements anywhere; on the other hand, there was marked evidence everywhere of a general good fellowship and of a desire to be helpful to one another and to coöperate in whatever seemed desirable for the promotion of the organization welfare.

It is a noteworthy fact that the scientific programs were of an exceptionally high order and that this condition was not solely, nor even mainly, due to the importation of "leaders of the profession" from the large cities of this or neighboring states; the addresses, papers and discussions presented by members of the local county organizations were, in most instances, quite equal to the standards set by the invited guests. This indicates a very healthy and promising condition and is a factor in the success of medical organization that should be further stimulated and developed in the work of all the societies.

The coöperation asked for by the officers of the State Society visiting these County meetings has been heartily accorded; unanimously so, in promises, and with but a single exception actively in the course of time. The Journal is dependent upon the officers of the County Society, mainly upon the Reporter or the Secretary, for an accurate and prompt report of the proceedings of these gatherings. Any value attributable to the publication of such proceedings will surely be in direct proportion to the "freshness" of the material submitted to readers. To publish in December or January, for instance, the transactions of sessions held in September would be ridiculous. To be of any real value, transactions should appear in print during the same or, at most, the succeeding month; of course, meetings held after the twentieth of any given month can scarcely run through the technical process involved in writing, editing and printing in time for the next monthly issue, but it is perfectly feasible to publish each month the reports of all meetings held prior to the twentieth of the preceding month.

We would respectfully appeal to all reporters to write up the proceedings of every meeting immediately after the close of that meeting. It is no more difficult to do it then than at any other time; in fact, it is much easier to do such work while the subject matter is fresh in mind than it is to accomplish the same task after the lapse of days or weeks and when the recollection of

salient points has become dimmed by the intrusion of other affairs. The Reporter's motto should be "Do it now." Writing while still under the stimulus of the session will give such reports a distinctly living quality that is just as certain to be missing from reports that must be prepared as a matter of duty at some belated period of time. Let us endeavor to put life, vigor and snap into our work and make these reports of such living value that all members of the State Society will be keen each month to receive and read accounts of the work done in each of the counties.

Finally, if your County Society is not being reported in the Journal, it will not be the fault of the Editor nor of the Publication Committee, but of your own officers and, in that event, it will become your duty to find out why your county is not keeping pace with and receiving the same benefits as the other branches of the State Society.

MEDICOLEGAL EXPERT TESTIMONY.

One of the most important, as well as interesting, papers presented to the local profession in the recent past, is that of Dr. Mefford Runyon, read as his Presidential Address before the Essex County Medical Society at its annual meeting in Newark, October 7, 1924, and published in this issue of the Journal.

It is only a few months since the sensational trial of two youthful criminals in Chicago attracted and held the attention of the newspaper-reading world, largely by virtue of the medical expert testimony submitted. The medical profession has not been spared criticism in the paper and magazine articles reporting and reviewing the conduct of that trial, and certainly the episode has been a most unpleasant one to contemplate. In many quarters, the charge is rather bluntly made that medical experts can be hired to testify to anything, reasonable or unreasonable, provided the pay is sufficiently high. And it is true that one cannot read the testimony of some of the witnesses in that case without confessing that there is a certain degree of justification for the adverse opinions expressed concerning the honesty of some of our confrères. One can readily recall other instances, too, in which the profession has been similarly stigmatized in consequence of conflicting opinions given by alleged ex-

perts appearing as opponents in court, and, unfortunately, these conflicting and sometimes scientifically absurd opinions seem particularly prone to occur in trials where considerable money is available to the defense side of the case.

What are we going to do about it? The subject would seem to demand the thoughtful consideration of every member of the profession and Dr. Runyon's exposition of the topic is certainly deserving of your attention if for no other reason than that he has developed his theme in such a masterful manner; without any ranting about a condition that is really deplorable, and without inconsiderate suggestions for radical action, he deals with the problem in a calm and sensible way, while recognizing that existing conditions and past performances are a stain upon the fair record of medical science, and that something should be done about it looking toward the prevention of further abuses of a sort that have scandalized all right-thinking people.

The Chairman of the Welfare Committee, Dr. McBride, has appointed Dr. Runyon as Chairman of a special Sub-Committee to take this matter under consideration and to advise what action, if any, should be taken by the State Medical Society, through legislation or otherwise.

COMMITTMENT OF THE INSANE.

In the report of the Bergen County Medical Society, appearing elsewhere in this number of the Journal, it will be observed that the November session of that body was devoted solely to consideration of a very serious problem that has arisen in that county through the prosecution of two members of the society for signing a certificate of insanity, and the decision of the Court awarding heavy damages to the plaintiff. It would seem impossible that such a thing could happen, but it actually has occurred, and thereby a whole series of vitally important questions are raised.

Any practitioner in the state may be called upon at any time, and practically every general practitioner of more than 10 years' experience has been called on one or more times, to participate in such an examination preparatory to commitment of a supposedly insane person. It is of the greatest importance that physicians shall know just what responsibilities they are assuming in such cases. In this particular

instance, the Court seems not to have been satisfied with the opinions of the County Physician, Dr. Ogden, and his Consultant, Dr. Freeland, that the patient was insane, and not even satisfied with the testimony of the Medical Staff of the State Hospital to which she was sent that the patient was and had been insane for a considerable length of time prior to the examination, but held that the defendants must prove not only that the patient was insane to a degree such as to be a *possible* menace to herself or to the community, but must prove beyond peradventure of doubt that she was a *probable* menace.

We had intended to publish along with the County Society proceedings a report of a special committee of the society that has investigated the circumstances surrounding the case, and also a transcript of the Judge's charge to the jury, but the matter is of such transcendent importance to every physician practicing in this state that it seems better to delay such publication until next month and to procure, if possible, a comprehensive summary of the charges and the testimony adduced at the trial, and to submit a complete explanation of this case, with comment as to its bearing upon our relations with patients whose sanity is in question.

THE WELFARE COMMITTEE.

Members of the Society will probably be pleased to hear that the Welfare Committee, under the Chairmanship of Dr. Andrew F. McBride, is actively engaged upon the larger problems that concern the organization. Since the first of October, two meetings of the full committee have been held, and the Chairman has appointed a number of sub-committees to give special consideration to a series of specific questions, so that these smaller groups of workers may give the necessary attention to minute details and bring the results before the large committee in shape for prompt action. Some of these sub-committees have already gotten down to their tasks and there is every prospect that by the end of this calendar year the Welfare Committee will have mapped out a definite course of action for the winter.

We shall take occasion to report upon the different topics as the work develops, so that members may be kept informed as to the progress being made.

County Society Proceedings

ATLANTIC COUNTY.

Joseph H. Marcus, M.D., Reporter.

The regular monthly meeting of the Atlantic County Medical Society was held at the Hotel Chalfonte, Friday, November 14, 1924. The newly elected officers for the ensuing year are: President: D. Ward Scanlan. Vice-President: Henry C. James. Secretary-Treasurer: Edward F. Uzzell (re-elected). Reporter: Joseph H. Marcus. Public Health Committee: W. Blair Stewart, Chairman; W. J. Carrington and Harvey. Board of Censors: Walt P. Conaway, Chairman; Samuel Barbash and William Martin. Library Committee: W. E. Darnall. Annual Delegates to State Meeting: Clarence L. Andrews, Philip Marvel, Jr., H. L. Harley, Joseph H. Marcus and H. C. James. Alternates: S. Salasin, Leland S. Madden, H. L. Silvers, C. H. Shivers and Jas. B. Mason. Permanent Delegate, to fill the vacancy made by retirement of J. A. Joy: Clarence L. Andrews. In recognition of Dr. Joy's long service and of his having retired from an honored active practice, he was elected an Honorary Member of the Society. New members were elected, as follows: S. Gorson, V. E. Johnson, J. C. Brown, A. W. Whealton and C. C. Allen.

Dr. Andrews, the retiring President, has filled that chair with exceptional ability for two years and he brought to a close a very successful and highly educational administration, during which time splendid scientific programs were the dominant feature. The incoming President, Dr. Scanlon, possesses an energetic mind, an originality of thought and an ability of expression that fit him splendidly to succeed to this office.

The Society went on record as opposed to the repeal of the Dog Vaccination Ordinance, for prevention of rabies, and adopted a set of resolutions condemning the prospective action of the Council as retrogressive and detrimental to the general welfare of the community. A committee was appointed to attend the final reading of this measure.

The scientific program consisted of two excellent papers: the first by Dr. George W. Norris, of Philadelphia, "Some Practical Points in Relation to the Diagnosis and Treatment of Heart Disease," and the second by Dr. William D. Stroud, of Philadelphia, on "The Prevention and Relief of Heart Disease."

Report of the Atlantic City Hospital Staff.

The October meeting of the Staff was held at the Breakers, October 17, 1924. The Medical Director, Dr. Richard Bew, presented a report on 3 cases of tumor of the brain, with autopsy findings. The Surgical Director, Dr. Theodore Senseman, reported a series of fracture cases, caused mainly by automobile accidents. Many of them were of such character as to require open reduction. The nature of fracture and stages of progress in healing were illustrated by numerous x-ray plates. It was interesting to compare the work of the year, when fractures of the femur seemed to predominate, with the work of last year, when the service consisted largely of fractures of the skull; in that summer surgical service, 14

fractured skulls were admitted within one 24-hour period.

The September meeting of the Staff was held at the Hospital, and was devoted to a report on the Obstetrical Service, by Dr. Norman Quinn, and one on the Eye Clinic, by Dr. H. L. Harley.

BERGEN COUNTY.

Flora Adams, Reporter.

At the regular monthly meeting, held at the Hackensack Hospital Tuesday, November 18, the Bergen County Medical Society devoted its entire attention to a discussion of the laws and conditions governing the commitment of the insane to institutions. Interest has been directed to this question, and much indignation aroused, by the suit brought against two members of the society for the performance of their duty in a case of this type. Several officers of the State Society and a representation of the members of the Passaic County Society were present to evidence their wish to support Dr. Frank Freeland and Dr. W. E. Ogden in defending themselves and to protest against the unprecedented action of the judge and jury at the recent trial. The State Society Councillor for the District, Dr. Henry Spence, and the Chairman of the Welfare Committee, Dr. Andrew F. McBride, both expressed themselves as believing that the Appellate Court would over-rule the verdict and reverse the decision.

A special committee having been appointed at a previous meeting to consider this matter, reported through its chairman, Dr. Armstrong, the belief that the case should be carried through the higher courts, and that the society should take further action looking to the prevention of any similar condition arising in the future. It was pointed out that the physician who examines a patient for the purpose of determining his or her sanity is in no way responsible for the commitment of that person to an institution, but that such responsibility rests with the relatives or authorities asking for such commitment; the physician's sole consideration in examining such persons is the discharge of his duty in regard to the following points: (1) The securing of proper care and treatment for the mentally diseased; (2) the protection of the patient, if necessary, against himself; (3) the protection of the community.

Following a general discussion of this particular case and of the subject in general, the committee presented a series of resolutions which were unanimously adopted by the society:

It is recommended that in so far as investigation of the supposedly insane person is concerned, it should be taken out of the hands of the court and put into the hands of a special commission; that no person be examined in the jail except when under arrest; that no person shall be examined for commitment except after a court hearing; that an officer, or officers, be furnished by the court for the protection of the examining physician when requested; that the fee for such examinations be raised to \$30., and that the examining physician be allowed a fee of \$3. per hour or fraction thereof for time spent at court hearings.

It is the wish of the Bergen County Medical

Society and of the New Jersey State Medical Society, to give wide publicity to their indignation at the injustice done two of their members, and, further, to give all the support possible to these physicians in the further defense of the suit.

CAMDEN CITY MEDICAL SOCIETY.

Henry B. Decker, M.D., Secretary.

The regular monthly meeting of the Camden City Medical Society was held on November 11, at the Camden Dispensary. Dr. F. W. Shafer presided.

The program was a symposium on fractures, by the surgeons of the society. Dr. F. W. Shafer spoke of the advantages of skeletal over skin traction; Dr. B. F. Buzby on the use of plaster of paris as a fracture dressing; Dr. S. G. Corpenning on fracture of the patella; Dr. W. J. Barrett on fracture of the femur; Dr. L. N. Conoly on fractures around the elbow; Dr. R. S. Gamon on fracture of the clavicle; and, Dr. A. S. Ross on the end-results of fractures. Dr. P. M. Mecray opened the discussion. The papers were brief; the time limit of five minutes being exceeded in but two papers, yet, in spite of the brevity, each paper covered all the points of interest. They were well illustrated with x-ray plates.

The application of Dr. E. P. Shope was received. Drs. E. W. Clark and A. S. MacCallum were elected to membership.

Dr. H. L. Rose represented a committee of the Camden County Medical Society. The question of the consolidation of the county and city societies, after remaining dormant for several years, has again arisen. The county society appointed a committee to confer with a similar committee from the city society. On motion, duly carried, the president appointed a committee to meet the committee of the county society.

At the next meeting the pediatricists of the society will discuss some of their problems.

ESSEX COUNTY.

Alfred Stahl, M.D., Reporter.

The 109th Annual Meeting of the Essex County Medical Society was held at the Academy of Medicine of Northern New Jersey, Newark, October 7, 1924. There was the usual large attendance. The Treasurer reported receipts for the year as \$6,921.22; Disbursements, \$5,094.68, including \$3,135. paid to the State Society; leaving a balance on hand of \$1,826.54. The Secretary reported that the Welfare Committee had an active year; its chief legislative interest being protection of the title of Doctor. The Milk Committee reported an increasing use of certified milk and that the Woodbrook and Fairfield dairies were certified by the Milk Commission.

The Society lost through death during the year: George Bancroft Gale, John Philip Rohn, Anna L. Smith and Herman C. Blyle.

The Committee on Automobile Emblems reported that about 150 members have placed orders for the emblems and that emblems may be still obtained from the Secretary at cost of \$1.20.

The retiring President delivered an extremely interesting address on "Medicolegal Expert Testimony" (published in this issue of the Journal).

Discussion on Periodic Health Examinations resulted in the appointment by the President of a committee to investigate methods in use elsewhere and to report at the next meeting.

Election of officers resulted in the choice of: President: C. R. O'Crowley. Vice-President: E. G. Wherry. Secretary: Frank Pinneo. Treasurer: H. R. Rogers. Reporter: Alfred Stahl. Councillors: E. J. Ill, W. P. Eagleton, H. Roy Van Ness and A. F. Dowd. Permanent Delegates to State Society: Frank Devlin, R. D. Freeman and P. H. Hosp. Nineteen new members were elected, as follows: Joseph Hunter Brooks, Montclair; Albert E. Cook, Caldwell; William John Davis, East Orange; Edvuge N. Dragonetti, Newark; L. C. Victor du Busc, Newark; James Joseph Edele, East Orange; Rosa Einhorn, Newark; Walker Allen Johnson, Orange; Louis Jean-Baptiste Lebel, Nutley; Louis Noll, Irvington; R. Pomeranz, Newark; William Rado, Newark; Marcus Schwarzmann, Newark; Byron J. Smith, Irvington; Henry G. Smith, Cedar Grove; Miguel Steinberg, Newark; Frank F. Thompson, Montclair; Helene G. L. Toal, Cedar Grove; Arthur William Wyker, Bloomfield.

The stated meeting of the Academy of Medicine of Northern New Jersey was held Wednesday evening, November 19, 1924, Dr. Henry J. F. Wallhauser presiding. Dr. Walter Gray Crump, formerly Professor of Surgery of the New York College and Hospital for Women, delivered a very interesting and instructive paper on "Acute Generalizing Peritonitis."

The Eye, Ear, Nose and Throat Section of the Academy held its regular monthly meeting November 10, 1924. Dr. Conrad Berens, of the New York Eye and Ear Infirmary, read a paper entitled, "Clinical Ocular Tumors." The speaker demonstrated these beautifully with many lantern slides. Dr. Fred C. Webner opened the discussion, after which general discussion of the paper ensued.

GLOUCESTER COUNTY.

Henry B. Diverty, Reporter.

The annual meeting of the Gloucester County Medical Society was held Thursday, November 20, at 1.30 P. M., at the Hotel Paul, Woodbury, N. J. Dr. John Kolmer, of the University of Pennsylvania Post-Graduate School of Medicine, delivered an address upon "Serum Sickness," presenting the practical aspects of the question as it must be considered by the general physician. An interesting discussion followed, during which several illustrative cases were reported. Dr. Duncan Campbell, of Woodbury, gave a talk upon "Preventive Medicine," and, Dr. Elwood Downs, of Swedesboro, reported several interesting cases of abdominal conditions, showing x-ray plates bearing upon their diagnosis.

Election of officers for the coming year resulted as follows: President: J. Harris Underwood, of Woodbury. Vice-President: H. Wilson Stout, of Wenonah. Secretary-Treasurer: Ralph K. Hollinshed, Westville. Reporter: H. B. Diverty. Censors: James Hunter, Jr., Duncan Campbell and Cyrus Philips. Delegate to State Society: Ralph K. Hollinshed; Alternates: David Brewer and E. E. Downs. Member of Nominating Committee State So-

ciety: William Brewer. Delegates to other County Societies: Atlantic: Drs. Hunter, Diverty and Philips. Burlington: Drs. Wood, Hunter and Brewer. Camden: Drs. Ashcraft, Fisher, Hunter, Clement and Diverty. Cumberland: Drs. Philips, Campbell, Underwood and William Brewer. Salem: Drs. Ashcraft, Downs and Stout.

Special Committee on Budget and Program: Drs. Diverty, Underwood and Hollinshed.

Among the guests in attendance were: Henry O. Reik, Editor of the State Society Journal; Walter P. Glendon, Councillor of the State Society; J. H. Moore, of Bridgeton; A. L. LeFevre, of Blackwood; W. W. Kain and E. A. Richardson, of Camden.

After adjournment of the business session, the members and guests gathered at dinner and enjoyed a lively social session.

HUDSON COUNTY MEDICAL SOCIETY.

Wm. Freile, M.D., F.A.C.S., Reporter.

The November meeting of the Hudson County Medical Society was held on the 11th inst. at the Jersey City Rehabilitation Clinic, Jersey Avenue, Jersey City. On account of Election Day falling on the first Tuesday, several of the local societies, including the Practitioners' Club, had postponed their meetings until this date, but notwithstanding this fact the attendance was commendable.

Dr. H. O. Reik, the new Editor of the State Journal, was present, and addressed the Society with reference to his work. Drs. Haskings and Yeaton were appointed as a committee to revise the constitution and by-laws.

Under routine business, Drs. Niemeyer and Yeaton were elected permanent delegates to fill the places of Drs. Mortimer Lampson and H. J. Bogardus, deceased. A communication from the American Society for the Control of Cancer, through Dr. Edward J. Ill, of Newark, asking the Society to devote one meeting to the discussion of cancer, was referred to the Program Committee. A communication from Dr. Ralph Lobenstein offering to furnish paper and speakers under the auspices of the Maternal Welfare Society, was also referred to the same committee.

The applications of Dr. H. Fiet of Jersey City, and Dr. Ainsley, Ford Motor Co., Kearny, were referred to the censors.

The meeting was then taken over by Dr. Andrew F. McBride, Commissioner of Labor, the Society being his guest. Dr. McBride mentioned that he was absolutely opposed to state medicine and would not accept any case at the clinic unless sent there by a regular M.D.; that the clinic was open to any regular M.D. for the treatment of his own cases if he so desired. Every injured person was to receive all that he or she was entitled to, no more and no less, from the Compensation Board. In order to properly adjudicate the compensation work, a reorganization had been effected so that instead of having only one Commissioner and one Deputy Commissioner for a formal hearing, there are now three. No medical bills which were justly refused payment by the insurance companies through the Compensation Bureau. He thought that about 95% of the cases should be brought up on an informal hearing and then and there settled.

Several interesting cases were then shown,

one, a nurse from Christ Hospital who had an infected hand with subsequent contractures, in which an excellent result was obtained, the work having been carried out by Dr. Wm. J. Arlitz. Another case was that of a paralysis of the major part of the left upper extremity, including a portion of the deltoid, biceps and triceps, which was restored to useful function after a considerable period of treatment. Another case exhibited was that of a paralysis following cerebral apoplexy, which showed almost complete restoration in the functions of the arm and leg. Several injured men had come on crutches and after six or eight weeks of treatment they were enabled to discard these appliances. Dr. McBride then demonstrated the Zander Apparatus, both motor driven and otherwise.

The members evidently enjoyed the demonstration and felt that the evening had been well spent.

MERCER COUNTY.

In lieu of a scientific meeting, the Mercer County Medical Society held its Annual Banquet at the Carteret Club, Trenton, on Thursday, November 20. There were approximately 100 members in attendance and the President, Dr. Alvin W. Atkinson, acted as Toastmaster. It was a most enjoyable evening; good dinner, good speeches, and a general jollification.

MONMOUTH COUNTY.

Harvey Brown, M.D., Reporter.

The regular October meeting of the Monmouth County Medical Society was held Wednesday, October 29, at 8.30 P. M., the members meeting as the guests of the Shrewsbury Dairy Company, and after an inspection of the dairy, going to the Shrewsbury Country Club for dinner. The session was attended by 25 members.

OCEAN COUNTY.

Geo. W. Lawrence, M.M., Reporter.

Regular meeting of the Ocean County Medical Society was held at Dr. Denniston's office, Point Pleasant, N. J., November 21, at 4 P. M. The present membership of the Society is 16, and 10 members were present at this meeting. Dr. Jones of Toms River, President, in the chair.

After the minutes of the previous meeting were read and approved, a letter was read from Mr. Strawbridge, representing the American Medical Association, who has been doing special detail work in this county to assist in procuring additional members. Mr. Strawbridge sent in applications for 2 new members; Dr. H. Pittis of Lakehurst and Dr. Morin of New Egypt, who were elected. Dr. Charles Ripley of Point Pleasant was proposed by Dr. Dr. Denniston and was also elected.

Treasurer's report shows a balance of \$14.50 in the treasury.

The following officers were elected for the ensuing year: President: Harold B. Disbrow; Vice-President: Robert Buermann; Secretary: Theodore R. Thompson; Treasurer: Irwin H. Hance; Annual Delegate: E. G. Herbener; Reporter: Geo. W. Lawrence.

Dr. Denniston demonstrated an easy method of taking blood pressure, using his storage air-tank for the source of air pressure. He also

demonstrated his apparatus for chlorin treatment for colds and bronchial affections.

A Committee on drafting and procuring new by-laws was appointed by the Chair and it was proposed that these by-laws be presented at the next regular meeting.

Meeting was adjourned at 5.15 subject to the call of the President.

Dr. Denniston served a very dainty lunch at 5.30.

PASSAIC COUNTY MEDICAL SOCIETY.

Louis G. Shapiro, Secretary.

The November meeting of the Passaic County Medical Society was held in the Chamber of Commerce Rooms, on Thursday evening, November 13th. Dr. John N. Ryan presided. The meeting was called to order at 9.15 P. M. Forty-two members and several visitors were present.

Dr. Louis G. Shapiro presented a case of anaphylaxis to cedar wood, in a carpenter 45 years old. The patient first became aware of his susceptibility seven years previously. He knows, now, that handling of cedar wood for but a short time causes lacrimation, protracted sneezing, tightness of the chest and dry cough. After several days, expectoration commences. Otherwise, the patient had always been well, except for a cough which developed easily but most readily in the late summer and early autumn. He has not had hay-fever nor asthma. The family history was irrelevant except that his mother had a chronic cough for years. The skin tests show a reaction to ragweed but no reaction to oil of cedar wood nor to cedar wood protein obtained from the Arlington Chemical Company. Squibb's laboratory reported that they were unable to prepare an extract from cedar wood but that they knew of several other cases of susceptibility to it.

Dr. Mackenzie suggested trying the opthalmic reaction and volunteered to prepare an antigen for the patient.

Dr. George M. Mackenzie of the Presbyterian Hospital, New York, gave an interesting paper on "The Treatment of Conditions Due to Allergy." He commented upon the close relationship between urticaria, eczema, and bronchial asthma, and pointed out the fact that the predisposition to these manifestations is hereditary, and that our knowledge of these diseases relates to the acute paroxysm and that we do not know the underlying basis for the disease. He grouped the inciting agents into: (1) The air-borne agents, pollens and the ectodermal proteins of animals; (2) food proteins; (3) bacterial proteins; (4) occupational causes, the latter are usually of the air-borne type.

Of the two methods of testing for susceptibility, the intracutaneous and the scratch methods, the scratch test is to be preferred because of the danger of severe reactions with the intracutaneous method. Death has occurred following intracutaneous tests with proteins, in highly sensitized individuals. The reaction to bacterial proteins is frequently of a different type than with the other test proteins. Very often the reaction is delayed and is of inflammatory character.

The simplest method of treatment is avoidance of the offending substance. Because this is not always feasible, desensitization is re-

sorted to. In highly susceptible individuals, one must proceed very cautiously with the injections, especially in going from one dilution to the next more concentrated one. The skin test is of some help, but cannot be relied upon implicitly. The patient's history as to his mode of reaction to the offending substance must be the guide. The condition of the nose is of secondary importance. Temporary improvement has followed nasal operative work, but no permanent result. The attitude toward nasal conditions from the standpoint of hay-fever and asthma should be that any real pathology should be remedied, as in patients without asthma. But no nasal operative work should be undertaken with the primary intent of influencing the asthma or hay-fever if no actual gross lesion is present.

An interesting discussion followed. Dr. Hagen brought up the question of the continued use of adrenalin by some of these patients. Dr. Mackenzie felt that in spite of the fact that arteriosclerosis is known to follow the continued use of adrenalin in laboratory animals, in humans apparently very little harm is done by its prolonged use, excepting that these patients become hopelessly dependent upon the adrenalin.

A rising vote of thanks was extended to Dr. Mackenzie for his interesting paper.

A communication from the Chamber of Commerce, Paterson, relative to the establishment of a physicians' and surgeons' bureau was read. The object of the bureau is to provide a central clearing house for calls for physicians and surgeons when they cannot be located at their own offices. The suggestion was made for the establishment of such a bureau at the Chamber of Commerce, with an all-day and night service. A committee was appointed to study the suggestion and make a report.

SUSSEX COUNTY.

H. D. Van Gaasbeek, M.D., Reporter.

The 95th annual meeting of the Sussex County Medical Society was held at the Cochran House, in Newton, Tuesday, October 21. The President and Vice-President both being absent, the meeting was called to order by the Reporter. Following the transaction of routine business, the members dined together at the hotel. The officers elected for the ensuing year are: President: H. J. Harp, of Sussex. Vice-President: T. L. Pellet, of Hamburg. Secretary: F. P. Wilbur, of Franklin. Treasurer: T. R. Pooley, Jr., of Newton. Reporter: H. D. Van Gaasbeek, of Sussex. Delegate to the State Society and Member of the Nominating Committee: B. W. Roy, of Sussex.

Death.

TIRICO.—Dr. Antonio B. Tirico, of 9 Clover Hill Place, Montclair, died suddenly while attending a patient in his office at 7.30 P. M., Friday, November 7, 1924. Dr. Tirico was 52 years of age, and the cause of his death was given by the County Physician as cerebral apoplexy. Born in Naples, Italy, Dr. Tirico received his degree at the University of Naples and came to this country twenty-three years

ago. He practiced in Newark for nine years and then moved to Montclair. He was a member of the Essex County Medical Society, the Medical Society of New Jersey, and the Sons of Italy.

Marriage.

WRIGHTSON - JOHNSON. — Dr. James T. Wrightson, 21 Walnut Street, Newark, was married to Mrs. Annie J. Johnson of 20 Clifton Avenue, Newark, on November 20, 1924.

News Items

Annual Meeting of the State Society.—The Secretary, Dr. J. B. Morrison, has announced, on behalf of the Board of Trustees, that the next Annual Meeting of the Medical Society of New Jersey will be held at Haddon Hall, Atlantic City, on Thursday, Friday and Saturday, June 18, 19 and 20, 1925.

Bonnie Burn Sanatorium.—Dr. John E. Runnells, Superintendent, reports that on October 1, there were 227 patients in the institution; 132 males and 95 females; this including 72 children in the Preventorium. The admissions have been classified as: Pretubercular, 2; Incipient, 4 Medium advanced, 6; and Far advanced, 15; making a total of 27 admitted since the last report.

Association of Life Insurance Medical Directors.—The 35th Annual Meeting of the Association was held at the Home Office of the Mutual Benefit Life Insurance Company, Newark, N. J., on October 23 and 24, 1924. The sessions were presided over by Dr. William R. Ward, of Newark, assisted by the Secretary, Dr. Chester T. Brown, also of Newark. The reading of many interesting papers, and their discussion, occupied all of the two day's sessions, and on Thursday evening a banquet was held at the Robert Treat Hotel, when an eloquent address was delivered by Mr. Edward Duffield, President of the Prudential Insurance Company, in which he strongly advocated loyalty to the Constitution and our old American ideals. Dr. George A. Van Wagenen, of Newark, sole survivor of the charter members of the Association, related some interesting reminiscences of the early history of the organization.

New York Post-Graduate Medical School.—Announcement has recently been made by the Dean of the School, that "Scholarships on the Oliver-Rea Foundation for graduate study in medicine are available at the New York Post-Graduate Medical School and Hospital. Inquiries should be addressed to the Dean, 301 East 20th Street, New York City."

New York Skin and Cancer Hospital.

Alumni New York Skin and Cancer Hospital graduates of this post-graduate school are requested to send their present professional office address to the secretary of the re-organized Alumni Association.

Dr. Herman Goodman.

15 Central Park West, New York City.

The following list of additional new members have recently been reported to the Secretary of the State Society: William Joseph Allen, Orange; Maurice L. Blaustein, Newark; John Dickson, Bogota; Morris Farkas, Newark; Jacob Goeller, Irvington; J. Vernon Hughes, Passaic; Leonard M. Matthews, Passaic; C. R. Neare, East Orange; J. S. Plant, Newark; William T. Ramage, Newark; Herbert A. Schulte, Newark; Henry G. Smith, Cedar Grove; Andrew Rados, Newark; Sidney B. Rawitz, Newark; and the following have been reinstated: Edmund W. Ill, Newark; John J. Kashkevich, Newark; H. E. Matthews, Orange; William E. Miller, Camden; Albert E. Cook, Caldwell; H. S. Cooley, Keyport; Herman B. Nash, 565 Bergen Street, Newark; G. H. Palmer, 10 N. Munn Avenue, East Orange. Resigned: E. M. Lyon, 282 Broad Street, Newark.

Personal Notes

At the Twelfth Convocation of the American College of Surgeons, held at the Waldorf-Astoria Hotel, New York City, October 24, 1924, the Fellowship degree was conferred upon Drs. A. J. Mitchell, Alfred Stahl and C. M. Robbins, all of Newark.

As we are about to go to press, Dr. J. B. Morrison is starting for Chicago to attend, as representative of the Medical Society of New Jersey, the Annual Conference of Secretaries of State Medical Societies.

Dr. and Mrs. Linus W. Bagg and daughter Barbara of 712 Clinton Avenue, Newark, spent Thanksgiving with Mrs. Bagg's mother, Mrs. Edward Hudson at Syracuse, N. Y.

Dr. and Mrs. James Spencer Brown of 43 South Fullerton Avenue, Montclair, have left for Pinehurst, N. C., where they will spend the winter.

Dr. Samuel E. Robertson of 21 Walnut Street, Newark, who has been on the staff of St. James Hospital for over twenty years, and its medical director for a large part of that time, has retired from this office to be succeeded by Dr. John F. Condon of Newark. A testimonial dinner at the Robert Treat Hotel was tendered to Dr. Robertson last month by the board of directors, the staff and the sisters of the hospital.

Dr. and Mrs. James H. Brothers of 123 Broad Street, Newark, recently entertained twenty friends at a Hallowe'en party in their home.

After a two months' trip abroad, Dr. and Mrs. Lester R. Davis of Elizabeth Avenue, Newark, arrived home on the "Pittsburgh" recently. Besides Monte Carlo and Paris, interesting places in Belgium, Holland, Switzerland and Italy were visited.

Dr. and Mrs. Edmund W. Ill of 53 Second Avenue, Newark, spent a week-end in Boston and attended the Princeton-Harvard football game on November 15th.

Dr. John T. English and family have moved from 18 Clinton Place, Newark, to 702 Stuyvesant Avenue, Irvington.

Dr. and Mrs. H. C. Barkhorn have returned to their home at 45 Johnson Avenue, Newark, from a ten-week European trip. They spent most of their time in Italy and Switzerland, and just before returning stayed for a week in Paris. They made the return trip by the southern route, sailing from Italy.

Dr. and Mrs. E. LeRoy Wood have returned from their trip to White Sulphur Springs, W. Va., where they were staying at the Greenbriar, and are now occupying their new home at 196 Roseville Avenue, Newark.

Dr. M. J. Fine, director of the tuberculosis division of the Newark Board of Health, with Dr. Samuel B. English, head of the State Tuberculosis Hospital at Glen Gardner, attended the fall meeting of the Eastern Section of the American Sanatorium Associations last month at Providence, R. I. Dr. English is secretary of the Executive Committee of the Section, and read a paper on "The Value and Method of Obtaining Records of Ex-patients."

Dr. and Mrs. Jesse D. Lippincott of 304 Summer Avenue, Newark, entertained, as is their custom, a house party of ten at their home for the Thanksgiving holiday.

Dr. and Mrs. Archibald Mercer of 31 Washington Street, Newark, spent Thanksgiving and the following week-end at Washington.

Dr. Mahlon C. Smalley of Gladstone entertained the Summit Medical Society at its regular meeting on November 28th at the Canoe Brook Country Club. The essayist for the evening was Dr. Edgar A. Ill of Newark, who presented an interesting and valuable paper on "Cancer."

The Skin Game.

It is the day of the big game. In the stand a fair damsel nestles into her Hudson Sealskin coat of muskrat fur, and adjusts her complexion with a scrap of chamois skin which once covered a young goat. Her hero jogs onto the field in his brown canvas moleskins and receives the pigskin of sheep's hide from a student manager clad in oilskin of paraffined linen. This is his last chance to star on the gridiron, for next June he will get his sheepskin nicely printed on the best bond. But, alas, it is not to be, for the whistle blows and he takes a place on the bench. He is only a substitute himself.—R. L. G., (Life).

Whatcha Mean "Exhausted" ?

Turkey is beginning to have trouble enforcing prohibition of plural marriage. Discontent probably is due to the fact that many leading Turks have exhausted their pre-war stocks.

—Life.

Danger!

New York newspapers are discussing the question, "What is an adventuress?" An adventuress is a woman you and your husband met a while ago, and your husband remarked, "Why not have her out to our house to dinner sometime?"

—Kansas City Star.

DATE DUE SLIP
UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL LIBRARY

THIS BOOK IS DUE ON THE LAST DATE
STAMPED BELOW

1m-8,'27

v.21	Medical society of New	
1924	Jersey.	
	Journal.	20286

20286

